Down Syndrome Association of Central California

Client Information

Name ____________________

Address ____________________ Apt. or Suite No. ______

City ____________________ State ____________ Zip Code ____________

Home Phone ( ) ____________ Cell ( ) ____________ Work ( ) ____________

E-mail Address ____________________

When service is available, would you like to receive E-mail... (*check all that apply*)

☐ Event Reminders ☐ Newsletter

For prenatal diagnosis, provide due date ____________________

*Name of your child with Down syndrome ____________________

Date of Birth ____________ ☐ Male ☐ Female

Relationship to person with Down syndrome (*check all that apply*)

Please Select From The Following:

☐ Person with Down syndrome
☐ Parent and/or Primary Care Giver
☐ Grandparent
☐ Sibling
☐ Healthcare Professional
☐ Educator
☐ Business Sponsor
☐ Agency Affiliate
☐ Donor
☐ Other ____________

What is the primary language spoken at home?

☐ English ☐ Spanish ☐ Other ____________

Would you like personal contact from a member of our Family Faculty? ☐ Yes ☐ No

Referred by: ____________________

Office Use:

Date added to mailing list: ____________

Date current information mailed: ____________

Processed by: ____________

Please fax or mail information to: **DSACC**
4277 W. Richert Ave., Suite 102, Fresno, Ca 93722
T (559) 228-0411 F (559) 228-0414
E-mail: info@dsacc.org

**If parents prefer not to provide personal information, kindly forward only date of birth and gender of baby*