Down Syndrome Association of Central California

Client Information/ Membership Form

Name:

Address: Apt. or Suite #:

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 the due date: / /

*Name of your child with Down syndrome

Date of birth / / ☐ Male ☐ Female

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

☐ 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 Parents Reaching Out program?

☐ **Yes** ☐ **No**

Referred by (Name & Organization):

Address:

Phone: ( ) E-mail

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

Office Use:

Date added to mailing list:

Date current information mailed:

Processed by:

Please fax or mail information to: **DSACC**
1491 West Shaw Avenue - Fresno, CA 93711
(559) 228-0411 Fax: (559) 228-0414
E-mail: info@dsacc.org