Membership is free of charge.
You must complete and mail this form to:

Down Syndrome Association of NWI
2927 Jewett Avenue
Highland, IN 46322

Membership Form

All fields in red must be completed. All other information is optional.
All information is confidential. Even if you consent to sharing information with other families, we will always contact you for your permission prior to proceeding with the exchange. We do not sell our mailing list or share it with other groups or organizations. The medical information is used to match families who have certain medical problems and call with requests to speak to someone who can share their concerns. We are asking for sibling information so that we may schedule events or workshops.

GENERAL INFORMATION

Please check one: ❑ Parent ❑ Professional ❑ Other (specify)

Name of Child with Down Syndrome: ____________________ Date of Birth: __________

Name of Child with Other Disability: ____________________ Date of Birth: __________

Mother's Name: ____________________ Date of Birth: __________

Father's Name: ____________________ Date of Birth: __________

Current Address: ____________________ City: __________ State: _____ ZIP: __________

Phone: __________ Cell or Work #: __________ E-Mail: ____________________

MISCELLANEOUS INFORMATION

Primary Language: ____________________ Secondary Language: ____________________

Ethnic Background: ____________________ Religious Background: ____________________

CHILD'S MEDICAL HISTORY (DS OR OTHER DISABILITY)

Child's Medical Condition (Please check all that apply):

❑ Heart ❑ Intestinal ❑ Hearing ❑ Vision ❑ Premature Birth

Orthopedic (specify): ____________________

Other (specify): ____________________

Skin (specify – alopecia, vitilgo, etc.): ____________________

Surgery: ____________________ Date: __________ Hospital: __________

Surgery: ____________________ Date: __________ Hospital: __________

Surgery: ____________________ Date: __________ Hospital: __________

Surgery: ____________________ Date: __________ Hospital: __________

Other persistent or recurring problems: ____________________

SIBLING INFORMATION

Name: ____________________ Date of Birth: __________

Name: ____________________ Date of Birth: __________

Name: ____________________ Date of Birth: __________

Name: ____________________ Date of Birth: __________

OR: This child has #____ male and/or #____ female siblings who are over 21 years of age.

I'D LIKE TO HELP - PLEASE CONTACT ME!

I would like to be used as a resource for other families? ❑ Yes ❑ No

I would be willing to speak to other parents? ❑ Yes ❑ No

I'd like to volunteer my help at: ❑ Christmas Party ❑ Awards Banquet ❑ Picnic ❑ Buddy Walk

I would like to help get speakers for Educational Meetings. ❑ Yes ❑ No