DSAGSL Membership form

Parent1/Guardian Name:			
Relationship to Individual with Down syndrome:			
Mailing Address:			
City/State/Zip:			
Mobile Phone:		Personal Email:	
Occupation:		Employer:	
Are you interested in volunteering?			

Parent2/Guardian Name:			
Relationship to Individual with Down syndrome:			
Mailing Address:			
City/State/Zip:			
County:			
Mobile Phone:		Personal Email:	
Occupation:		Employer:	

Contact Information - Individual with Down syndrome:

First Name:		Last Name:	
Primary address is with:			
Date of Birth:		Gender:	M F
Hospital of Birth:			

Ethnicity

☐ Native/ American Indian or Alaska Native ☐ Asian ☐ Indian (Asian)

☐ Black/African American ☐ Hispanic/Latino ☐ Native Hawaiian/ Pacific Islander

☐ White/Caucasian ☐ Biracial/Other _____

Do you or a member of your household qualify for public assistance (Medicaid, SNAP, WIC) in the state of Missouri or Illinois? ☐ Yes ☐ No