



# MEMBERSHIP APPLICATION GREAT ESCAPES™

Starlight Children's Foundation™ MidAtlantic is excited to invite your family to join our *Great Escapes* program. The GE program invites children through the age of 18, with chronic or serious illnesses, or debilitating injuries and their families, to attend special outings and events. Starlight MidAtlantic plans the event, all you have to do is show up!

Please complete and return this form as soon as possible. The application process takes approximately 2 weeks. Once the form is processed, you will be added to our GE mailing list to receive information on upcoming events. **If you have additional children with a medical condition that qualifies for the *Great Escapes* program, please fill out additional Membership Applications.**

*The Starlight MidAtlantic is committed to protecting the privacy and the confidentiality of the personal information collected by SCFM from our employees, families and volunteers. The information you provide will be used to deliver services and to keep you informed and up to date on the activities of the Starlight MidAtlantic.*

## PARENT/GARDIAN INFORMATION

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ County: \_\_\_\_\_  
Phone: \_\_\_\_\_ Phone 2: \_\_\_\_\_  
Email: \_\_\_\_\_

## CHILD'S INFORMATION

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Male / Female  
Allergies or dietary requirements: \_\_\_\_\_  
Any additional special needs: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_ Date Diagnosed: \_\_\_\_\_  
Hospital/Clinic: \_\_\_\_\_  
Family Doctor: \_\_\_\_\_  
Phone: \_\_\_\_\_ Date of Last Treatment: \_\_\_\_\_  
Current Medical Condition: \_\_\_\_\_  
Is condition progressive? Yes \_\_\_\_\_ No \_\_\_\_\_ Cognitive Age: \_\_\_\_\_  
Estimated # of hospital visits last year: \_\_\_\_\_  
Estimated # of school days missed last year due to medical condition: \_\_\_\_\_

## REFERRAL SOURCE

Name: \_\_\_\_\_ Title: \_\_\_\_\_  
Hospital/Organization: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Date of Referral: \_\_\_\_\_

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## HOUSEHOLD MEMBER INFORMATION

Name (First and Last)	Relation to Child	Sex	Date of Birth
		M/F	
		M/F	
		M/F	
		M/F	
		M/F	
		M/F	
		M/F	

Does anyone need wheelchair seating? Yes \_\_\_\_\_ No \_\_\_\_\_ How many? \_\_\_\_\_

Number of Adults in Family: \_\_\_\_\_ Number of Children in Family: \_\_\_\_\_

Total # of members in household: \_\_\_\_\_

Is your family nurse/care provider needed for event: Yes \_\_\_\_\_ No \_\_\_\_\_

What are your families' hobbies, interests, etc.? \_\_\_\_\_

## DEMOGRAPHIC INFORMATION (optional)

Answering the questions below is optional; however, by completing them you may help Starlight MidAtlantic secure funding to grow our programs. Thank you.

### Ethnicity:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Alaskan Native         | <input type="checkbox"/> American Indian | <input type="checkbox"/> Asian            |
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> Hispanic/Latino | <input type="checkbox"/> Pacific Islander |
| <input type="checkbox"/> White/Caucasian        | <input type="checkbox"/> Other           |   |

### Household Income:

- |  |  |
|--|--|
| <input type="checkbox"/> less than \$20,000  | <input type="checkbox"/> \$20,000 - \$35,000 |
| <input type="checkbox"/> \$35,000 - \$50,000 | <input type="checkbox"/> over \$50,000       |

## Please return completed application(s) to:

**DC Area Great Escapes Coordinator  
(Chapter Office)  
Starlight MidAtlantic**  
2020 K Street, NW, Suite 600  
Washington, DC 20006  
Tel (202) 293-7827  
Fax (202) 293- 9060  
Farrah@starlight-midatlantic.org

**Philadelphia Great Escapes  
Coordinator  
Starlight MidAtlantic**  
PO Box 7219  
Audubon, PA 19407-7219  
Tel (267) 455-3039  
Fax (610) 917-2152  
Cathy@starlight-midatlantic.org

**Richmond Great Escapes  
Coordinator  
Starlight MidAtlantic**  
PO Box 42363  
Henrico, VA 23242  
Tel (804) 536-7490  
Fax (804) 447-1140  
Sandi@starlight-midatlantic.org

### FOR STARLIGHT MIDATLANTIC USE

Starlight Name: _____	Date: _____
Approved/Enrolled: _____	Entered in DB: _____
Welcome Letter Sent: _____	Date: _____