



Great Escapes™ Membership Form

Starlight Children's Foundation is excited to invite your family to join our *Great Escapes*™ family activities program. The *Great Escapes* 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 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 *Great Escapes* 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 Forms.**

CHILD'S INFORMATION

Child's 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: _____
(Please exclude visits for common childhood illnesses)

PARENT/GUARDIAN INFORMATION

Parent's First Name: _____ Last Name: _____
Parent's First Name: _____ Last Name: _____
Address: _____
City, State Zip: _____ County: _____
Phone: _____ Phone 2: _____
Email: _____

HOUSEHOLD MEMBER INFORMATION

Name (first and last)	Relationship	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? _____

Total # of members in household: _____

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

Tell us about your families' hobbies, interests, etc.

REFERRAL SOURCE

Name: _____ Title: _____
Hospital/Organization: _____
Phone: _____ Email: _____
Date of Referral: _____

Would you like to receive Starlight's newsletter? Yes No

DEMOGRAPHIC INFORMATION (optional):

Starlight seeks sponsors to help fund the Great Escape program. Some of these sponsors are interested in some information about the families we serve. We do not collect this information as measures for acceptance into the Great Escapes program, but it would help us secure funding from some sources. Do not feel obligated to answer the following questions.

Ethnicity: Alaskan Native American Indian
 Asian Black/African-American
 Hispanic/Latino Pacific Islander
 White/Caucasian Other

Household Income: less than \$20,000 \$20,000 – \$35,000
 \$35,000 – \$50,000 over \$50,000

Number of Adults in Family: _____ Number of Children in Family: _____

Starlight Children's Foundation is committed to protecting the privacy and the confidentiality of the personal information collected 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 Starlight.

*Please return your completed application to:
Starlight Children's Foundation
ATTN: Mark Ford, Community Development Officer
Starlight Children's Foundation Texas
4848 Lemmon Avenue
100-426
Dallas, TX 75219
Mark.Ford@starlight.org.*

For Starlight use

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