

Wigs 4 Kids Salon and Wellness Center

30126 Harper Ave.
St. Clair Shores, MI 48082
(586) 772-6656 FAX: (586) 772-6674
www.wigs4kids.org

Client Application Form

To be eligible for the Wigs 4 Kids program you need to complete all forms. As a wig recipient, you are an Ambassador of the program, and we request the following:

- A prescription from your physician
- Write a thank you letter to your Adopt-A-Kid sponsor
- Before and after photos
- Complete pre, post and satisfaction surveys
- If you know of a child in need of our services, please let them know about our program
- Participate (when health permits) in Wigs 4 Kids fundraising events

Your participation ensures that the program will be in existence for future children.

Date of Application: _____

Full Name: _____

First

Middle

Last

Date of Birth: _____ Age: _____

Female: _____ Male: _____ Ethnicity: African American _____ Arab American _____ Asian American _____
Caucasian _____ Hispanic American _____ Other _____

Street Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Home phone number:(_____) _____

Mother's/Guardian full Name: _____

Cell number:(_____) _____ Work:(_____) _____

Father's/Guardian full Name: _____

Cell number:(_____) _____ Work:(_____) _____

Email address: _____

Alternate contact person:

Name _____ Relationship to client _____

Address: _____ City: _____

State: _____ Zip: _____ Phone Number:(_____) _____

PARENT/GUARDIAN

SIGNATURE: _____

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Client Application Form (page 2)

Medical Information:

Do you have a prescription for a cranial prosthesis (wig)? _____yes _____no

What is your medical diagnosis: _____

Are you currently undergoing medical treatment? _____yes _____no

If yes, what type of treatment: _____

Have you already experienced hair loss? _____yes _____no

Name of your physician: _____

Hospital/OfficeAddress: _____

City: _____ State: _____

Zip: _____

Telephone number: (_____) _____

Referral Information:

Name of Organization/Hospital: _____

StreetAddress: _____

City: _____ State: _____

Zip: _____

Phone Number: (_____) _____

ContactPerson: _____

Title: Doctor _____ Nurse _____ Social Worker _____ Other _____

For Office Use Only

Received by: _____

Approved by: _____