

# Wigs 4 Kids

29314 Harper Ave. St. Clair Shores, MI 48081  
(586) 772-6656 FAX: (586) 772-6674

Date of Application: \_\_\_\_\_

Client #: \_\_\_\_\_  
(Office Use)

## Client Application Form

**To be eligible for the Wigs 4 Kids program, please complete the 2-page client application and bring a prescription from your physician or a medical referral from the hospital. \***

First Name: \_\_\_\_\_ Middle Name : \_\_\_\_\_ Last Name: \_\_\_\_\_

Month, Day and Year of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Female  Male

Ethnicity: African American  Arab American  Asian American  Caucasian  Hispanic American  Other

Street Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Area code and phone number: \_\_\_\_\_ -- \_\_\_\_\_ -- \_\_\_\_\_

### Parent or Guardian Contact Info:

Parent or Guardian full name: \_\_\_\_\_

Parent or Guardian's email address: \_\_\_\_\_

Area code and CELLULAR phone number: \_\_\_\_\_ -- \_\_\_\_\_ -- \_\_\_\_\_

Area code and WORK phone number: \_\_\_\_\_ -- \_\_\_\_\_ -- \_\_\_\_\_

### Alternate Contact Info:

Name: \_\_\_\_\_

Relationship to client: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

\* As a recipient of a wig from Wigs 4 Kids we ask you to be an ambassador for the program which includes:

1. Writing a thank you letter to your Adopt-A-Kid sponsor
2. Participating (when health permits) in Wigs 4 Kids fundraising events
3. Telling other kids about the Wigs 4 Kids program.

Additionally we will take Before and After photos, and you will need to complete pre- and post-program surveys and a satisfaction survey. Your participation means that the Wigs 4 Kids program will be available for other kids with hair loss that need assistance. **By filling out and signing this form, you agree to all of the above conditions for your child. If you do not wish for your child to participate in the program as outlined, Wigs 4 Kids can provide a wig at the full retail price.**

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

# Wigs 4 Kids

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? \_\_\_\_\_

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Have you already experienced hair loss?    yes     no

Name of your physician: \_\_\_\_\_

Hospital/Office Address: \_\_\_\_\_

City : \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Area code and phone number: \_\_\_\_\_ -- \_\_\_\_\_ -- \_\_\_\_\_

## Referral Information:

Name of Organization/Hospital: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact Person at Medical Facility: \_\_\_\_\_

Title: Doctor     Nurse     Social Worker     Other

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## For Office Use Only

Date Received \_\_\_\_\_ by: \_\_\_\_\_

Approved by: \_\_\_\_\_