

du Ballon Rouge

Tourette Syndrome Association of Texas



CHILD'S PROGRAM APPLICATION

All Information is confidential.

Child's Name: _____
Last First Middle Initial

Address: _____
City State Zip Code

Sex: Male _____ Female _____ Age: _____ Birthdate: _____

School: _____ Grade next fall: _____

Lives with both parents _____ Lives with one parent: Father _____ Mother _____ Guardian _____

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Mother's Name Home Phone Cell Phone E-mail Address

Place of Business Address, City, State, Zip

() ()

Position Business Phone Fax Number

() ()

Father's Name Home Phone Cell Phone E-mail Address

Place of Business Address, City, State, Zip

() ()

Position Business Phone Fax Number

EMERGENCY NOTIFICATION - In the event we are unable to contact parent(s) in an emergency, we will call the following persons regarding your child. If parents are out of town during the week of the program, we must have a number where they may be reached.

Emergency Contact () Home Phone () Business Phone

Street City State Zip Code

Emergency Contact () Home Phone () Business Phone

Street City State Zip Code

Tourette Syndrome Association of Texas
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