

Free Wigs for Kids REGISTRATION FORM

(Please Print)

To be eligible for the Free Wigs For Kids program, you must complete this form for approval, the applicant must be under the age of 18, and be diagnosed with a medical condition causing hair loss. We encourage all applicants to participate in our reference program to help ensure that this program will be in existence for future children. By signing this form you agree to the above conditions.

Today's date:

APPLICANT INFORMATION

First Name:

Middle:

Last:

Sex?

Female Male

Birth Date

/ /

Age:

Ethnicity:

African American Arab American Asian American Hispanic
 American Indian Caucasian Hispanic Other Decline

Street address:

City/State:

Zip:

Home Phone:

()

Cell:

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Email:

I was referred by: Dr. Insurance Plan Hospital Social Worker Family Friend Other

Parent/Guardian Full Name:

Home Phone:

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Cell:

()

Email:

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, please describe]

Have you already experienced hair loss? Yes No

Name of your physician:

Phone:

()

Address:

Parent/Guardian signature

Date

For Office Use Only

Received by:

Date Received: / /

Approved by:

Free Wigs For Kids™

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