BUTTERFLIES BY BLAQ INC.

REGISTRATION APPLICATION

www.ButterfliesBBI.org

(Please Print)

Today's date:				

CLIENT INFORMATION

Child's last name: First: Middle I:			❑ Miss ❑ Mstr:	
Street address:		Home phone no: ( )		Ethnicity:
P.O. box:	City:		State:	ZIP Code:
Age:	Birth Date: / /			Sex: M F

How did you hear about us? (please check one box): ❑ Dr. ❑ Internet ❑Radio

❑ Family ❑ Friend ❑ Television ❑ Google Search ❑ Other

School Attending:

Interested in The Pink Butterflies Program: Yes No

PARENT/GUARDIAN INFORMATION:

Parent/Guardian Last name:	First name:	Address (if different):	Home phone no.: ( )

Work no: ( )	Alt no: ( )	Email:	Cell phone no.: ( )

Child's Name:

Relationship to child:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

Required Documents:
1. Doctor's Diagnosis, (can be faxed)
2. Photo of child (with and with our hair if possible)
3. Letter of recommendation (not mandatory)

Notes
For Office Use Only

Patient/Guardian signature

Date

ALL INFORMATION PROVIDED IS CONFIDENTIAL AND WILL NOT BE SHARED

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