

Laura Baker Services Association

Family Support Services Application Form

Child's Name: _____

Date of Birth: _____ Diagnosis: _____

Emergency Contact: Please list someone who will be able to take over the responsibility of caring for your client if his or her stay needs to be ended prior to the agreed upon time, or if we are unable to reach you in an emergency:

Name: _____

Address: _____

Phone: _____

Relationship: _____

Signature/Person(s) Responsible for payment: _____

The following licensed Physician is authorized to give emergency care to my child

Physician's Name:	Address:
Phone:	City, State, Zip

If unavailable, another licensed Physician may treat my child. Yes No

What YMCA programs are you enrolling in?

Activity	Cost

What level of supervision does your child need?

1:4 Staffing	Note:
1:3 Staffing	Note:
1:2 Staffing	Note:
1:1 Staffing	Note:

Contact Rose at 507-301-1841 or email this application to her at rose@laurabaker.org