**APPLICATION FOR SERVICES**

**MISSISSIPPI INTELLECTUAL/DEVELOPMENTAL DISABILITIES PROGRAMS**

**HUDSPETH REGIONAL CENTER**

P. O. Box 127-B

Whitfield, MS 39193

(601) 664-6130; fax: (601) 354-6143

***Please complete ALL of the following information as it relates to the person for whom services are being sought.***

| 1. **IDENTIFYING INFORMATION:**
 |
| --- |
| ***Applicant – please complete the following in relation to the applicant*** |
| **Name in Full:**  |
|  **First Middle Last** |
| **Preferred Name:** |
| **Street Address: City: State: Zip:** |
| **Mailing Address: City: State: Zip:** |
| **County:** |
| **Date of Birth: Age: Gender: Race:** |
| **Marital Status: Social Security #:** |
| **Home Phone: Cell Phone:** |
| **Work Phone: Email address:** |
| **Fax: Other (specify):** |
| **What is the best way to contact applicant? (circle one) home phone cell phone work phone** |
|  **text message email fax other (explain)**  |
| **Alternate phone or email if we cannot reach applicant at the above numbers:** |
| **Length of residence in Mississippi How many people live in the home?** |
| ***Person Completing Application – please complete the following in relation to the person completing*** ***the application*** |
| **Name in Full:**  |
|  **First Middle Last** |
| **Is Person Completing Application (circle one): Self Legal Representative**  |
|  **Other (explain):**  |
| **Street Address: City: State: Zip:** |
| **Mailing Address: City: State: Zip:** |
| **County:** |
| **Home Phone: Cell Phone:** |
| **Work Phone: Email address:** |
| **Fax: Other (specify):** |

| **What is the best way to contact the person completing the application? (circle one)**  |
| --- |
|  **home phone cell phone work phone**  |
|  **text message email fax other (explain)**  |
| **Alternate phone or email if we cannot reach the person completing the application at the above numbers:**  |
| 1. **CURRENT SITUATION:**
 |
| **Correspondent’s name:** | **Phone #:** |
| **Correspondent’s relationship with applicant:** |
| **Who referred you?** |
| **Why is application being made at this time? Explain:** |
|  |
| **What services are you interested in? Check all that apply:** \_\_\_\_\_IDD Community Support Program (1915i)\_\_\_\_\_ID/DD Waiver \_\_\_\_\_Residential Placement \_\_\_\_\_Community Living Services\_\_\_\_\_Vocational Services \_\_\_\_\_Other/Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Are you seeking services in (circle all that apply):** Institutional Setting Home/Community Setting |
| **Who is caring for applicant now?** |
| **Is applicant currently receiving any services? If so, check all that apply and provide description** **and contact information:**  |
| \_\_\_\_\_Early Intervention | Description: |
| Address: |
| Phone #: |
| \_\_\_\_\_School  | Description: |
| Address: |
| Phone #: |
| \_\_\_\_\_Community Mental Health Center  | Description: |
| Address: |
| Phone #: |
| \_\_\_\_\_Day Program | Description: |
| Address: |
| Phone #: |
| \_\_\_\_\_Employment Related Services | Description: |
| Address: |
| Phone #: |
| \_\_\_\_\_Community Living | Description: |
| Address: |
| Phone #: |
| \_\_\_\_\_Home Health  | Description: |
| Address: |
| Phone #: |
| \_\_\_\_\_Physical Therapy  | Description: |
| Address: |
| Phone #: |
| \_\_\_\_\_Occupational Therapy | Description: |
| Address: |
| Phone #: |
| \_\_\_\_\_Speech Therapy | Description: |
| Address: |
| Phone #: |
| \_\_\_\_\_Private Duty Nursing | Description: |
| Address: |
| Phone #: |
| \_\_\_\_\_Elderly and Disabled Waiver  | Description: |
| Address: |
| Phone #: |
| \_\_\_\_\_Independent Living Waiver | Description: |
| Address: |
| Phone #: |
| \_\_\_\_\_Traumatic Brain Injury/ Spinal Cord Injury Waiver | Description: |
| Address: |
| Phone #: |
| \_\_\_\_\_Assisted Living Waiver | Description: |
| Address: |
| Phone #: |
| \_\_\_\_\_Hospice | Description: |
| Address: |
| Phone #: |
| \_\_\_\_\_Other/Explain: |
| Address: |
| Phone #: |
| **C. SKILLS, ABILITIES AND BEHAVIOR:** |
| **Does applicant walk independently? No Yes** |
| **Does applicant use crutches? No Yes**  |
| **Does applicant use canes? No Yes**  |
| **Does applicant use a wheelchair? No Yes** |
| **Does applicant use a scooter? No Yes**  |
| **Is applicant limited to bed? No Yes** |
| **Does applicant use the restroom without assistance?**  |
| **Is applicant continent of bowel? No Yes** |
| **Is applicant continent of bladder? No Yes** |
| **Does applicant see well? No Yes** |
| **Wear glasses? No Yes** |
| **Wear contacts? No Yes** |
| **Does applicant have vision impairments that limit reading or travel? No Yes** |
| **Does applicant have little or no functional vision? No Yes** |
| **Does applicant hear normally? No Yes** |
| **Wear hearing aids? No Yes** |
| **Does applicant have little or no functional hearing? No Yes** |
| **Does applicant feed him/herself? No Yes** |
| **Does applicant require support with eating? No Yes**  |
| **If so, circle one of the following:** |
|  No support Minimal support Total support |
| **Does applicant use a nasogastric or gastrostomy feeding tube? No Yes** |
| **How does applicant attend to personal grooming needs? Circle answer:** |
| No support Minimal support Total support |
| **How does applicant communicate? Circle all that apply:** |
|  words gestures sounds  |
|  eyes communication device sign language facial expression |  |
| Other(explain): |
| **If the applicant speaks, is speech easily understood?** |
| **Does applicant dress/undress self? No Yes** |
| **Explain.** |
| **Does applicant do simple chores around the house? No Yes** |
| **If yes, explain:** |
| **Is applicant hurtful to self? No Yes**  |
| **If yes, explain:** |
| **Is applicant hurtful to others? No Yes** |
| **If yes, explain:** |
| **Does applicant destroy property? No Yes** |
| **If yes, explain:** |
| **Does applicant have disruptive behavior? No Yes** |
| **If yes, explain:** |
| **If applicant has disruptive behavior, does it occur in (circle all that apply):**  |
| School Home Community |
| **Does applicant have unusual or repetitive habits? No Yes** |
| **If yes, explain:** |
| **Does applicant display socially inappropriate behavior? No Yes** |
| **If yes, explain:** |
| **Does applicant have withdrawn/inattentive behavior? No Yes**  |
| **If yes, explain:** |
| **Does applicant have temper tantrums? No Yes**  |
| **If yes, explain:** |
| **Does applicant have behaviors that show he/she does not want to do as asked? No Yes** |
|  **If yes, explain:** |
| **Does applicant have any other problematic behavior not listed above? No Yes**  |
|  **If yes, explain:** |
| **Can applicant read? No Yes** |
| **If yes, how well?** |
| **Can applicant write? No Yes** |
| **If yes, how well?** |
| **Can applicant count? No Yes**  |
| **If yes, how well?** |
| **D. SERVICE AND VOCATIONAL HISTORY:** |
| **Has the family ever consulted/been seen by anyone about these issues before now?** |
| If so, by whom? Name: |
| When? From (beginning date) To (ending date) |
| Where? |
| If so, by whom? Name: |
| When? From (beginning date) To (ending date) |
| Where? |
| **Has applicant ever had a psychological evaluation?** |
| If so, by whom? Name: |
| When? Date:  |
| **Has applicant ever been admitted to a medical hospital, psychiatric hospital, or institution for** **individuals with intellectual disabilities?** |
| Name of Hospital/Institution:  |
| Address: |
|  Street Address City State Zip |
| From (beginning date): To (ending date): |
| Reason for hospitalization: |
| Name of Hospital/Institution: |
| Address: |
|  Street Address City State Zip |
| From (beginning date): To (ending date): |
| Reason for hospitalization: |
| Name of Hospital/Institution: |
| Address: |
|  Street Address City State Zip |
| From (beginning date): To (ending date): |
| Reason for hospitalization: |
| **Has applicant ever been employed?** |
| Name of Employer: |
| Address: |
|  Street Address City State Zip |
| From (beginning date): To (ending date): |
| Name of Employer: |
| Address: |
|  Street Address City State Zip |
| From (beginning date): To (ending date): |
| Name of Employer: |
| Address |
|  Street Address City State Zip |
| From (beginning date) To (ending date) |
|  |
|  |
| **What is applicant’s school history? Please list schools attended and dates of attendance:**  |
| School/Address | Dates of Attendance | Highest Grade Reached |
|  |  |  |
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|  |  |  |
| **Did applicant participate in special educational services? No Yes** |
| **If so, What was applicant’s special education ruling?** (e.g., specific learning disability, intellectual disability) |
| **Did applicant complete formal education? No Yes** |
| **If yes, what year?** |
| **Did applicant receive (circle the one that applies):** diploma certificate of completion |
| **Was applicant ever removed from school? Explain:** |
|  |
| **Has applicant received additional services besides the ones listed above?** |
| If yes, list below.  |
| Circle type of services received: psychiatric educational vocational residential medical |
| Provider Name:  |
| Address: |
| Contact #: |
| Description of service: |
| From (beginning date) To (ending date) |
| Circle type of services received: psychiatric educational vocational residential medical |
| Provider Name: |
| Address: |
| Contact #:  |
| Description of service: |
| From (beginning date) To (ending date) |
| Circle type of services received: psychiatric educational vocational residential medical |
| Provider Name: |
| Address: |
| Contact #:  |
| Description of service: |
| From (beginning date) To (ending date) |
| **List applicant’s medical diagnoses:** |
|  |
|  |
| **List applicant’s current physician(s):** |
|  |
| **Has applicant ever had a seizure? No Yes** |
| **If yes, at what age?** |
| **Has applicant continued to have seizures? No Yes** |
| **If yes, how often?** |
| **Has applicant ever had a serious accident or injury? No Yes** |
| **If yes, explain:** |
| **Does applicant have allergies to food, medication, etc.? No Yes** |
| **If yes, explain:** |
| **If so, for how long?**  |
| **List medications the applicant currently takes:** |
| Name of Medication: |
| Dosage:  | Frequency: |
| Medication type (circle one): prescription non-prescription: |
| Prescribing physician: |
| Reason prescribed: |
| Name of Medication: |
| Dosage:  | Frequency: |
| Medication type (circle one): prescription non-prescription: |
| Prescribing physician: |
| Reason prescribed: |
| Name of Medication: |
| Dosage:  | Frequency: |
| Medication type (circle one): prescription non-prescription: |
| Prescribing physician: |
| Reason prescribed: |
| Name of Medication: |
| Dosage:  | Frequency: |
| Medication type (circle one): prescription non-prescription: |
| Prescribing physician: |
| Reason prescribed: |
| Name of Medication: |
| Dosage:  | Frequency:  |  |
| Medication type (circle one): prescription non-prescription: |
| Prescribing physician: |
| Reason prescribed: |
| **E. DEVELOPMENTAL HISTORY** |
| **Where was applicant born?** |
| **City:** | **State:**  |
| **Hospital:**  |
| **Were there any illnesses, infections, or unusual symptoms during pregnancy? No Yes** |
| **If yes, please explain:**  |
|  |
| **Was applicant under a physician’s care during pregnancy? No Yes** |
| **If yes, for how long (in months)?**  |
|  | **List medication mother took during pregnancy and reason:** |
|  | Name of Medication:  |
|  | Medication type (circle one): prescription non-prescription: |
|  | Reason: |
|  | Name of Medication: |
|  | Medication type (circle one): prescription non-prescription: |
|  | Reason: |
|  | Name of Medication: |
|  | Medication type (circle one): prescription non-prescription: |
|  | Reason: |
|  | **Has applicant been exposed to drugs? No Yes** |
|  |  **If yes, was it during mother’s pregnancy? No Yes** |
|  |  **If yes, was it after mother’s pregnancy? No Yes** |
|  | **Has applicant been exposed to alcohol? No Yes** |
|  |  **If yes, was it during mother’s pregnancy? No Yes** |
|  |  **If yes, was it after mother’s pregnancy? No Yes** |
|  | **Has applicant been exposed to tobacco? No Yes** |
|  |  **If yes, was it during mother’s pregnancy? No Yes** |
|  |  **If yes, was it after mother’s pregnancy? No Yes** |
|  | **Explain applicant’s mother’s general health during pregnancy?** |
|  | **Was applicant a full-term baby? No Yes** |
|  | **If no, in what month did birth occur? (1-9)** |
|  | **Was labor (circle one) Spontaneous Induced** |
|  | **Did applicant’s mother have any of the following during birth? (circle those that apply)** |
|  | **excessive bleeding convulsions/seizures attempts made to stop labor** |
|  | **Was anything unusual about the delivery? No Yes** |
|  | **If yes, explain:** |
|  |  |
|  | **Was birth Cesarean? No Yes** |
|  | **Was the cord around applicant’s neck? No Yes** |
|  | **Did applicant breathe immediately after birth? No Yes** |
|  | **If no, explain:** |
|  | **Was there anything unusual about the applicant that was noted at birth? No Yes** |
|  | **If yes, explain:** |
|  | **Birth weight: Birth length:** |
|  | **Did physician attend birth? No Yes If yes, Name of physician:** |
|  | **Was applicant born in a hospital? No Yes If yes, name of hospital:** |
|  | **Did applicant go to the NICU? No Yes**  |
|  | **If yes, why?** |
|  | **For how long (# of days)?** |
|  | **Was genetic testing conducted? No Yes** |
|  | **If yes, what were the results?** |
|  | **Did applicant receive early intervention services? No Yes** |
|  | **If yes, who was the provider:** |
|  | **Length of service (in years):**  |
|  | **Services provided:** |
|  |  |
|  | **At what approximate age did applicant do the following?**  |
|  |  | **Years** |  **Months** |  |  **Years** |  **Months** |
|  |  Follow objects with eyes |  |  |  Hold head up |  |  |
|  |  Roll over |  |  |  Babble |  |  |
|  |  Sit alone |  |  |  Say “Mama” or “Dada” with  meaning  |  |  |
|  |  Walk independently |  |  |  Talk |  |  |
|  |  Crawl |  |  |  Feed self |  |  |
|  | 1. **FAMILY INFORMATION**:
 |
|  | **Are applicant’s biological parents married to each other?** |
|  | **Date of marriage: Date of Separation: Date of Divorce:** |
|  | **Are the biological parents related to each other? No Yes** |
|  | **If yes, explain:** |
|  |  **Applicant’s father:** |
|  | **Name of applicant’s father:** |
|  | **Date of birth: Age at birth of applicant:**  |
|  | **Is applicant’s natural father deceased? No Yes** |
|  | **If yes, what is the date of death?** |
|  | **Age of death? Cause of death?** |
|  | **Street Address: City: State: Zip:** |
|  | **Primary telephone #: Other phone #:** |
|  | **Address of birthplace:** **Street Address: City: State: Zip:** |

| **Marital Status (check one):** \_\_\_\_\_Married to applicant's natural parent \_\_\_\_\_Divorced from applicant's natural parent \_\_\_\_\_Never married to applicant's natural parent - Married \_\_\_\_\_Never married to applicant's natural parent - Not Married \_\_\_\_\_Remarried \_\_\_\_\_Widowed |
| --- |
| **Highest Level of Education Completed (check one):**\_\_\_\_\_None\_\_\_\_\_Elementary\_\_\_\_\_Middle\_\_\_\_\_High School\_\_\_\_\_Undergraduate\_\_\_\_\_Graduate |
| **Current Occupation:** |
| **Current Place of Employment:** |
| **Is applicant’s father a current or former military employee? No Yes** |
| **If yes, indicate branch of service:** |
| **Service number: VA Number:** |
| **Current health status (circle one):**   **Good Fair Poor** |
| **Explain if fair or poor:** |
| **Is there a history of any of the following in the natural father's family?**  |
| **Intellectual Disability? No Yes**  |
| If yes, check which relative:\_\_\_\_\_Natural Mother \_\_\_\_\_Maternal Grandfather\_\_\_\_\_Maternal Grandmother\_\_\_\_\_Maternal Aunt\_\_\_\_\_Maternal Uncle \_\_\_\_\_Maternal Cousin |
| Short History: |
| How It Affects Applicant: |
| **Developmental Disability? No Yes**  |
| If yes, check which relative:\_\_\_\_\_Natural Mother \_\_\_\_\_Maternal Grandfather\_\_\_\_\_Maternal Grandmother\_\_\_\_\_Maternal Aunt\_\_\_\_\_Maternal Uncle \_\_\_\_\_Maternal Cousin |
| Short History: |
| How It Affects Applicant: |

| **Psychiatric Disorder? No Yes**  |
| --- |
| If yes, check which relative:\_\_\_\_\_Natural Mother \_\_\_\_\_Maternal Grandfather\_\_\_\_\_Maternal Grandmother\_\_\_\_\_Maternal Aunt\_\_\_\_\_Maternal Uncle \_\_\_\_\_Maternal Cousin |
| Short History: |
| How It Affects Applicant: |
| **Cancer? No Yes** |
| If yes, check which relative:\_\_\_\_\_Natural Mother \_\_\_\_\_Maternal Grandfather\_\_\_\_\_Maternal Grandmother\_\_\_\_\_Maternal Aunt\_\_\_\_\_Maternal Uncle \_\_\_\_\_Maternal Cousin |
| Short History: |
| How It Affects Applicant: |
|  **Applicant’s mother:** |
| **Name of applicant’s mother:** |
| **Date of birth: Age at birth of applicant:** |
| **Is applicant’s natural father deceased? No Yes** |
| **If yes, what is the date of death?** |
| **Age of death? Cause of death?**  |
| **Street Address: City: State: Zip:** |
| **Primary telephone #: Other phone #:** |
| **Address of birthplace:****Street Address: City: State: Zip:** |
| **Marital Status (check one):** \_\_\_\_\_Married to applicant's natural parent \_\_\_\_\_Divorced from applicant's natural parent \_\_\_\_\_Never married to applicant's natural parent - Married \_\_\_\_\_Never married to applicant's natural parent - Not Married \_\_\_\_\_Remarried \_\_\_\_\_Widowed |
| **Highest Level of Education Completed (check one):**\_\_\_\_\_None\_\_\_\_\_Elementary\_\_\_\_\_Middle\_\_\_\_\_High School\_\_\_\_\_Undergraduate\_\_\_\_\_Graduate |
| **Current Occupation:** |
| **Current Place of employment:** |
| **Is applicant’s mother a current or former military employee? No Yes** |
| **If yes, indicate branch of service:** |
| **Service number: VA Number:** |
| **Current health status (circle one):**  **Good Fair Poor** |
| **Explain if fair or poor:** |
| **Is there a history of any of the following in the natural mother's family?** |
| **Intellectual Disability? No Yes**  |
| If yes, check which relative:\_\_\_\_\_Natural Mother \_\_\_\_\_Maternal Grandfather\_\_\_\_\_Maternal Grandmother\_\_\_\_\_Maternal Aunt\_\_\_\_\_Maternal Uncle \_\_\_\_\_Maternal Cousin |
| Short History: |
| How It Affects Applicant: |
| **Developmental Disability? No Yes**  |
| If yes, check which relative:\_\_\_\_\_Natural Mother \_\_\_\_\_Maternal Grandfather\_\_\_\_\_Maternal Grandmother\_\_\_\_\_Maternal Aunt\_\_\_\_\_Maternal Uncle \_\_\_\_\_Maternal Cousin |
| Short History: |
| How It Affects Applicant: |
| **Psychiatric Disorder? No Yes**  |
| If yes, check which relative:\_\_\_\_\_Natural Mother \_\_\_\_\_Maternal Grandfather\_\_\_\_\_Maternal Grandmother\_\_\_\_\_Maternal Aunt\_\_\_\_\_Maternal Uncle \_\_\_\_\_Maternal Cousin |
| Short History: |
| How It Affects Applicant: |

| **Cancer? No Yes** |
| --- |
| If yes, check which relative:\_\_\_\_\_Natural Mother \_\_\_\_\_Maternal Grandfather\_\_\_\_\_Maternal Grandmother\_\_\_\_\_Maternal Aunt\_\_\_\_\_Maternal Uncle \_\_\_\_\_Maternal Cousin |
| Short History: |
| How It Affects Applicant: |
| **Household:** |
| **Please list all other people living in the household.** |
|  **Name** |  **Date of Birth** |  **Age** |  **Gender** |  **Relationship** |
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| **Adoption Information (complete if applicable)s:** |
| **Date of adoption: Age of applicant at time of adoption:** |
| **Date applicant placed with adoptive parents:** |
| **Adoption agency:** |
| **Adoptive mother’s name: Date of birth:** |
| **Address:** |
| **Phone #: Social Security #:** |
| **Current health status (circle one):**  **Good Fair Poor** |
| **Explain:** |
| **Occupation: Current employer:** |
| **Adoptive father’s name: Date of birth:** |
| **Address:** |
| **Phone #: Social Security #:** |
| **Current health status: Good Fair Poor** |
| **Explain:** |
| **Occupation: Current employer:** |
| **Applicant’s siblings:** |
| **List applicant’s siblings including those deceased. Also note any miscarriages or stillborns.** |
| **Name** | **Date of Birth** | **Age** | **Health/Mental Status** (good, fair, poor) |
|  |  |  |  |
|  |  |  |  |
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|  |  |  |  |
| **Siblings, cont.** |
| **Name** | **Date of Birth** | **Age** | **Health/Mental Status** (good, fair, poor) |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **Explain any mental health or medical conditions noted in siblings:** |
|  |
| **G. REPRESENTATIVE INFORMATION** |
| **Name in Full:**  |
|  **First Middle Last** |
| **Relationship to Applicant (circle one): spouse parent/stepparent child/stepchild** |
|  **other relative physician case manager self** |
|  **other (specify):** |
| **Home Phone: Cell Phone:** |
| **Work Phone: Email address:** |
| **Fax: Other (specify):** |
| **What is the best way to contact you? (circle one) home phone cell phone work phone** |
|  **text message email fax other (explain)**  |
| **Alternate phone or email if we cannot reach you at the above numbers:** |
| **Street Address: City: State: Zip:** |
| **Mailing Address: City: State: Zip:** |
| **County:** |
| **Is Representative Any of the Following? (check all which apply)** |
| **\_\_\_\_\_Guardian of person****\_\_\_\_\_Guardian of property****\_\_\_\_\_Current surrogate** **\_\_\_\_\_Current representative payee****\_\_\_\_\_Current power of attorney contact****\_\_\_\_\_Current durable power of attorney contact****\_\_\_\_\_Current case manager or service coordinator contact****\_\_\_\_\_Current physician****\_\_\_\_\_Current emergency contact** |
| **Explain:** |
| **H. FINANCIAL INFORMATION:** |
| **Does applicant receive benefits from:** |
| **SSI? Amount: Payee:** |
| **SSDI? Amount: Payee:** |
| **VA Benefits? Amount: Payee:** |
| **Other? Amount: Payee:** |
| **Does applicant have Medicaid? No Yes If yes, provide Medicaid #:** |

| **Does applicant have medical insurance other than Medicaid?** |
| --- |
| **If so, indicate whether applicant has:**  |
| **Medicare #:** |
| **CHAMPUS:** |
| **Private Health Insurance:** |
| **Monthly income of applicant:** |
| **Monthly income of parents:** |
| **LEGAL GUARDIANSHIP/CONSERVATORSHIP:** |
| ***Applicants over the age of 18 are considered to be competent adults unless legal guardianship/*** ***conservatorship have been obtained through the courts.*** |
| **Has a legal guardian/conservator been appointed by the court?** |
| **Name of legal guardian/conservator:** |
| **Address of legal guardian/conservator:** |
| **Date legal guardianship/conservatorship appointed:** |
| **If legal guardianship/conservatorship has been appointed, court documents must be returned with** **this application for services.** |

I certify that the information provided in the application for services is complete and accurate to the best of my knowledge.

|  |  |  |
| --- | --- | --- |
| Signature of Person Seeking Services |  | Date |
|  |  |  |
| Signature of Person Completing Application |  | Date |
|  |  |  |
| Signature of Father |  | Date |
|  |  |  |
| Signature of Mother |  | Date |
|  |  |  |
| Signature of Legal Guardian/Conservator |  | Date  |