



Down Syndrome Association of Acadiana
Membership Information

Family's Last Name _____ Parent(s) or/Guardian(s) _____

Address _____

City _____ Parish _____ State _____ Zip Code _____

Home Phone _____ Office Phone _____ Cell Phone _____ E-Mail Address _____

Child's Name with Downs _____ Date of Birth _____

Other Conditions** *(codes on back if desired)* _____

School Child Attends _____ or _____ Home Schooled, Home Bound or Early Steps _____

Names of Siblings _____

I hereby give permission for my name and contact information to be printed in the Down Syndrome Association of Acadiana Member Directory. Yes No

I would like my child with Down syndrome's name be included in the newsletter Birthday listing. Yes No

I would like to volunteer for DSAA or serve on a committee. Yes No

Membership Type: New Renewal

Family \$20 Relationship to child if other than parent _____

Scholarship Donation \$5 \$10 \$_____ Other Amount _____

Professional \$50 - \$99 \$100 - \$250 \$251 - \$499 \$500+

Professional Affiliation _____

Exempt (families of babies under 1 year old)

I wish to be a member but am unable to pay dues this year

Photo Release

I, _____, hereby consent to and authorize the use and reproduction of images of myself and my minor child(ren) by the Down Syndrome Association of Acadiana (DSAA) in publications produced by DSAA including, but not limited to, its newsletter, promotional materials and on DSAA's web site. DSAA does not include children's names in such materials without the express permission from the parents. I also hereby certify that I am the parent or guardian of the above listed minor(s) and do give consent without reservation to the foregoing on behalf of said minor child(ren) to DSAA.

Signature _____ Date _____

*Please make checks payable to **Down Syndrome Association of Acadiana** and return this form with payment to Down Syndrome Association of Acadiana, P. O. Box 81323, Lafayette, LA 70508-1323. DSAA is a 501 (c)3 (non-profit) organization. Contributions in excess of the minimum \$20 membership fee are tax deductible.*

DSAA Use Only	Date Received: _____	Amount _____	Check # _____
	Cash _____	Payment Received by: _____	

Condition Codes**

A	Adopted	HB	Home Bound
AL	Allergy	HS	Home Schooled
AR	Arthritis	IM	Immune Dysfunction
AS	Asthma	K	Kidney
AU	Autistic	L	Leukemia
CL	Cleft lip or palate	M	Mosaic
CD	Celiac Disease	ND	Neurodevelopmental
D	Deceased	O	Other than Down
DI	Diabetes	R	Respiratory Problem
EA	Ears (tubes, etc)	S	Sinus
EP	Epilepsy	SD	Sleep Disorder
EY	Eyes	SS	Speech
FT	Feeding Tube	T	Translocation
GC	Grandchild	TE	Teeth (braces, palate expander, etc)
GH	Group Home	TO	Tonsillectomy
GI	Gastro intestinal problem	TR	Tracheotomy
H	Heart	TW	Twin
HA	Hearing Aid	TY	Thyroid