

**FAMILY APPLICATION
FAMILY FRIENDS PROGRAM**

**Bucks County Intermediate Unit # 22
705 Shady Retreat Road
Doylestown, PA, 18901
1-800-770-4822 X 1729**

NAME: _____ SEX: _____ DATE: _____

ADDRESS: _____ PHONE: _____

CITY/TOWN: _____ STATE: _____ ZIP CODE: _____

DATE OF BIRTH: _____ DISABILITY: _____

SCHOOL: _____ TEACHER: _____

FATHER'S NAME: _____ OCCUPATION: _____

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**MOTHER'S
NAME:** _____ **OCCUPATION:** _____

WORK PHONE #(F): _____ **WORK PHONE #(M):** _____

PHYSICIAN'S NAME: _____ **PHONE #:** _____

**PHYSICIAN'S
ADDRESS:** _____

MOBILITY (PLEASE CHECK APPROPRIATE INFORMATION)

___ **Manual Wheelchair** ___ **Electric Wheelchair** ___ **Braces**

___ **Prosthesis** ___ **Walker** ___ **Crutches** ___ **Other (list)**

SEIZURES? **YES** **NO** **TYPE:** _____ **LAST SEIZURE** _____

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ALLERGIES: _____

MEDICATIONS: _____

BOWEL/BLADDER PROBLEMS: _____

COMMUNICATION SKILLS: _____
(*Oral, Visual, Auditory*)

over

IDENTIFY CHILD'S HOBBIES AND INTERESTS: _____

WHAT ACTIVITIES WOULD YOU LIKE A VOLUNTEER TO ENGAGE IN WITH YOUR CHILD:

PLEASE GIVE A BRIEF DESCRIPTION OF YOUR CHILD. _____

LIST SIBLINGS AND THEIR AGES:

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LIST ANY OTHERS LIVING IN YOUR HOUSEHOLD & RELATIONSHIP TO CHILD:

PARENT/GUARDIAN SIGNATURE

DATE

Upon receipt of this application, families will be contacted by a *Family Friends* staff person.

We regret that *Family Friends* will not be able to match all of the families requesting our service.