



SUPPORT ORGANIZATION FOR TRISOMY 18, 13 AND RELATED DISORDERS Membership join/renewal

PARENT Name(s): _____

Mail Address: _____

Street City/Town State/Province Country Zip Code

Phone: (____) _____ E-mail: _____

CHILD's Name: _____ Sex: (circle) M _ F_ Date of Birth: ____ / ____ / ____

Cause of Death: _____ Date of Death: ____ / ____ / ____

Affected Chromosome: 18 13 Other: _____ (please specify)

Diagnosis: Full Mosaic Partial Translocation: _____ (please specify)

Other (please explain): _____

Child Health inquires: Providing SOFT with information about your child's growth, immunizations and surgeries is optional. This data might be of help for other families or for medical studies concerning our children. We would appreciate your input.

Growth: (Circle all that apply)

How is (or was) your child fed? Tube Bottle Breast Cup Spoon other Is (or was) your child able to self fed? YES NO with help

Birth weight: _____ (lbs/oz) Birth Length: _____ (inches)

Current date: _____ Current Weight: _____ (lbs/oz) Current Length: _____ (inches)

If your child is no longer living please provide last known measurements at what approximate age _____

Immunizations: (circle answer where applies)

1.) Is your child or, if no longer living, was your child up-to-date with your state recommended immunizations? YES NO Don't Know

2.) Is (or was) your child on a delayed immunization schedule? YES NO

3.) Did you decline (refuse) any immunizations? NO ALL SOME (explain) _____

4.) Did your child receive the Synagis series for prevention of RSV? YES NO Declined shot series

5.) Does (or did) your child receive a seasonal flu vaccine every year? YES NO Declined vaccine

7.) If your child had any reactions to any vaccines/shots, please explain which immunization and reaction. _____

Surgical Information: SOFT receives frequent inquires about surgeries. If additional space is needed, use 'add surgery' button first to make as many lines as needed on web registration, then fill fields or send requested information on separate page, if filling out a paper form.

Table with 5 columns: #, Date, Name of Surgery, Name, City, State of Hospital, Name of Doctor, Successful? Rows 1 and 2.

SOFT Survey: (Circle answer where applies)

1.) How did you learn about SOFT? Health Care Provider Another SOFT parent WEB site Other (explain) _____

2.) Barb Van Herreweghe is the contact person for states that do not have a local chapter chair. Have you been in contact with Barb? YES NO

3.) Have you been in contact with someone from your state or near-by state that is your state's local SOFT chapter chair? YES NO

4.) Only for those renewing their membership: Are you interested in being a chapter chair contact for SOFT families in your state? YES NO

~ SUBSCRIPTION INFORMATION: U.S. = \$25; All Other Countries = \$35 in U.S. Funds ~ MULTIPLE YEAR SUBSCRIPTIONS ARE WELCOME!

We now accept either VISA or MasterCard

VISA _____ MasterCard _____ Card # _____ Exp. Date: ____ / ____ month / year

Last 3 digits on back of the card: _____

Signature: _____ Date: _____

Joey Watson Fund: This fund was established to help financially challenged families attend the annual SOFT Conference. If you wish to donate to this fund, please add a donation to your membership fees.

Joey Watson Fund: _____ (amount of donation)

PLEASE SEND THIS FORM AND PAYMENT TO:

SOFT Membership Committee, c/o Barb VanHerreweghe, 2982 South Union St., Rochester, NY 14624

We assume that your name may be shared with other SOFT members unless you specify otherwise.

FOR U.S. FAMILIES ONLY: WE DEPEND ON SUBSCRIPTIONS TO SUPPORT PUBLISHING AND MAILING COSTS, BUT IF YOU CANNOT AFFORD SUBSCRIPTION AND STILL WISH TO RECEIVE THE NEWSLETTER, PLEASE CALL BARB VANHERREWEGHE AT (800) 716-7638 FOR INFORMATION ABOUT A LIMITED NUMBER OF SCHOLARSHIPS.

Membership Renewal.doc [07/14/2009]

~ IF YOU HAVE RECENTLY SENT YOUR RENEWAL, PLEASE DISREGARD THIS NOTICE ~

SEE SOFT'S HOMEPAGE FOR INFORMATION ABOUT SOFT AND THE NEXT CONFERENCE: http://www.trisomy.org

(800) 716-SOFT (7638)

