Wigs 4 Kids Wellness Center & Salon
30126 Harper Ave.
St. Clair Shores, MI 48082
(586) 772-6656 FAX: (586) 772-6674
www.wigs4kids.org

Client Application Form

To be eligible for the Wigs 4 Kids program you need to complete all forms. As a wig recipient, you are an Ambassador of the program, and we request the following:

-A prescription from your physician
-Write a thank you letter to your Adopt-A-Kid sponsor
-Before and after photos
-Complete pre, post and satisfaction surveys
-If you know of a child in need of our services, please let them know about our program
-Participate (when health permits) in Wigs 4 Kids fundraising events

Your participation ensures that the program will be in existence for future children.

Date of Application:_____

Full Name:_____
First **Middle** **Last**

Date of Birth:_____ Age:_____

Female:____ Male:____ Ethnicity: African American ___ Arab American___ Asian American___
Caucasian___ Hispanic American___ Other_____

Street Address:_____Apt. #_____

City:_____ State:_____ Zip:_____

Home phone number:(_____)_____

Mother's/Guardian full Name:_____

Cell number:(_____)_____ Work :(_____)_____

Father's/Guardian full Name: _____

Cell number:(_____)_____ Work:(_____)_____

Email address:_____

Alternate contact person:
Name_____ Relationship to client_____

Address:_____City:_____

State:_____ Zip:_____ Phone Number:(_____)_____

PARENT/GUARDIAN
SIGNATURE:_____

Wigs 4 Kids Salon and Wellness Center

Client Application Form (page 2)

Medical Information:

Do you have a prescription for a cranial prosthesis (wig)? _____yes _____no

What is your medical diagnosis:_____

Are you currently undergoing medical treatment? _____yes _____no

If yes, what type of treatment:_____

Have you already experienced hair loss? _____yes _____no

Name of your physician:_____

Hospital/OfficeAddress:_____
City: _____ State:_____
Zip:_____

Telephone number: (_____)_____

Referral Information:

Name of Organization/Hospital:_____
StreetAddress:_____
City:_____ State:_____
Zip:_____

Phone Number: (_____)_____
ContactPerson:_____
Title: Doctor _____ Nurse _____ Social Worker _____Other_____

For Office Use Only

Received by:_____

Approved by:_____