| WSF Membership form |
| --- |
| Parent / Carer / Relative /professional |
| Full Name:  | Spouse / Partner: |
| Current address: |
| Town: | Post Code: | Relationship: |
| Mobile: | Email: |
| WS Child / adult |
| Full Name:  |
| Current address: |
| Phone: | E-mail: |
| Date of Genetics test:  | Sex: Male / Female | DOB:  |
| Lives with:  | Hospital:  |
| Emergency Contact |
| Name of emergency contact:  | Relationship: |
| Address: | Phone: |
| Educational setting |
| Name of school: |
| Mainstream / SEN: | Town: | Guidelines required: Yes / No |
| Siblings |
| Name: | Age: |
| Name:  | Age: |
| Other  |
| I am a UK tax payer and enclose a completedGift Aid Declaration Form | YES / NO |
| I wish to pay future subscriptions by Direct Debit and enclose a completed mandate  | YES / NO  |
| I give the WSF express permission to contact me by all media with regard to all its activities. | YES / NO |
| The WSF has permission to use my/my child’s photograph in future WSF publications, web pages and any other informative and/or promotional materials | YES / NO |
| I have provided proof of diagnosis (we will be unable to proceed with membership without this) | Yes / NO |
| Signatures |
| I confirm the above is true & to the best of my knowledge and I will update the WSF with any changes to my contact details.  |
| Signature of applicant: | Date: |

Dear prospective member of the WSF

Please complete this questionnaire, this is to ensure we have all your correct details on file, and to help us run as smoothly as possible and to build up a data bank about Williams Syndrome.

Please answer on behalf of your WS family member

1. Also diagnosed with Infantile Hypercalcaemia? **YES** [ ]  **NO** [ ]  **Unsure** [ ]
2. Prescribed Locasol (Low calcium formula)? **YES [ ]  NO [ ]  Unsure** [ ]
3. Any other diagnoses? **YES** [ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **NO** [ ]
4. Any surgical procedures / Operations **YES [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NO [ ]**
5. Behavioural issues? **YES [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NO [ ]**
6. Which educational setting are they / were they in?  **N/A[ ]  Mainstream** [ ]  **SEN** [ ]  **Mixed** [ ]
7. Do they have a statement / ECHP? **YES [ ]  NO [ ]  In process** [ ]
8. If an adult what is their living situation? **N/A** **[ ]  Supported living** [ ]  **With family**[ ]  **Independent** [ ] Please state support level \_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
9. If adult does someone have Power of attorney / Deputyship? **YES [ ]  NO [ ]  In process** [ ]  **N/A** **[ ]**
10. Weight issues? **Overweight** [ ]  **Underweight**[ ]  **Healthy Weight** [ ]
11. If adult what is employment situation or how do they occupy time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Medication? **YES** [ ]  please state \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**NO**[ ]
2. Monitored in line with the WS Clinical Guidelines? **YES** [ ]  **NO** [ ]  **Not Yet [ ]**
3. Therapy? (eg Phsysio, OT, Speech & Language, Music, Art, Counselling etc) **YES**[ ] **NO**[ ]
4. Please state: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Do they have a Social Worker / Health Visitor **YES [ ]  NO [ ]**
6. Do they receive benefits **YES** [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**NO** [ ]
7. Do they have a Blue Badge **YES [ ]  NO [ ]  Unsure** [ ]
8. Do they have a Care Package **YES [ ]  NO [ ]  Unsure** [ ]
9. If pre-school are they using portage (National Portage Assoc) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
10. Are you in touch with your Regional Contact **YES [ ]  NO [ ]  Unsure** [ ]
11. Anything else you would like us to know? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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