# AUCKLAND DOWN SYNDROME ASSOCIATION INC.

## DATABASE FORM

**PLEASE RETURN FORM TO:** Auckland Down Syndrome Association Inc, PO Box 132033, Sylvia Park, Auckland 1644

| NAME OF PERSON WITH DOWN SYNDROME | |
|---|---|
| Last name: | First name: |
| Date of birth: | Gender: |
| Ethnicity: | |
| Address: | |
| | Postcode: |
| **PRIMARY CAREGIVER'S CONTACT INFORMATION** | |
| Last name: | First name: |
| Phone number: | Mobile number: |
| Email Address: | Occupation: |
| **SECONDARY CONTACT INFORMATION** | |
| Last name: | First name: |
| Phone number: | Mobile number: |
| Email Address: | Occupation: |
| **HELP THE ADSA** | |
| Would you be interested in helping the association on occasion? | |
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***Please turn the page***

| RELATIONSHIP | |
|---|---|
| ☐ | You are the person with Down syndrome |
| ☐ | Parent |
| ☐ | Sibling |
| ☐ | Grandparent |
| ☐ | Other |
| **TYPE OF DOWN SYNDROME** | |
| ☐ | Trisomy 21 |
| ☐ | Mosaic |
| ☐ | Translocation |
| ☐ | Unknown |
| **DIAGNOSIS BEFORE BIRTH** | |
| ☐ | Yes |
| ☐ | No |
| **FURTHER INFORMATION** | |
| Would you please provide details about any medical condition(s)/health issues – eg. heart defect, colostomy, vision, hearing – if applicable: | |
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| Would you like to become a member of the National Down Syndrome Association (there may be a cost involved): | |
| ☐ | Yes – a membership form will be sent to you from the National Office |
| ☐ | No |