

By becoming a member of APHH and signing below, I automatically authorize APHH, their affiliates, sponsors, grantors and any company/organization collaborating with APHH on a member hospital or home visit, event or gathering to photograph, video and/or record my likeness and that of my heart child and family members or anyone under my supervision at the time and to use such photographs, videos and recordings for purposes related to the mission of APHH. I hereby grant the same waiver and release on behalf of a spouse who is not present and all other event participants for whom I am the parent or legal guardian or who is attending an event/gathering under my supervision.

Print Name

Signature

Heart Shadow Buddy™ Order

When you become a member, your heart child receives a free Heart Shadow Buddy™ from Angel's Pediatric Heart House (APHH). Please select type of buddy that best represents your child.



If your child has already received a Heart Shadow Buddy™ check here: _____

Male _____ Female _____

Skin Tone:

Light _____ Medium _____ Dark _____

Hair Color: (For light skin tones only -- medium and dark skin tones only come with black hair)

Black _____ Blonde _____ Reddish/Brown _____

(Shadow Buddies is a registered trademark of the Shadow Buddies Foundation, Lenexa, Kansas)

FOR APHH USE ONLY

Buddy Mail Date: ____ - ____ - ____



angel's pediatric
heart house

...helping families cope with congenital heart defects

MEMBERSHIP FORM

A 501(c)(3) Nonprofit Organization
Supporting Children Affected
By Congenital Heart Defects

Mailing Address:

151 N. Nob Hill Road, #139

Plantation, FL 33324

(954) 318-2020

www.aphh.org info@aphh.org

Mail this form to address above

Today's Date: ____ / ____ / ____

Heart Child's Full Name: (Please print)

Child's Birth Date: ____ - ____ - ____

Male ____ Female ____

School/Current Grade (if applicable)

Cardiologist's Name:

Hospital: _____

Heart Defect(s): _____

Mailing Address:

Apt. # _____

City: _____

State: _____ Zip: _____

Circle or Write in County: Broward Dade

Palm Beach Other: _____

Parent's E-Mail Address: (only one is necessary)

Mother/Legal Guardian's Name

Father/Legal Guardian's Name

Does child live with both biological (natural) parents?

Yes ____ No ____

Home Phone: _____

Cell Mom: _____

Cell Dad: _____

Child's Hobbies (if applicable):

List siblings (brother or sisters) under 18 years old living with family - (Name, Age and Gender)

APHH seeks grants to help fund its programs and services. Some of these grantors are interested in information about the families we serve, which helps us secure funding. We do not collect this information as measures for acceptance into our programs and it **is not** shared with any third parties.

Race/Ethnicity: American Indian ____ Asian ____
Black ____ Hispanic ____ Caucasian (White) ____
Multi-racial _____

Household Income: Is your total income less than \$65,400? Yes ____ No ____

- How many heart surgeries has your child had? ____
- Does your child require additional heart surgeries in the future? Yes ____ No ____ Unsure ____
- If your child is over 2 1/2 years and under 18, has he/she ever been granted a wish by any granting organizations (Make A Wish)? Yes ____ No ____
- Has your family ever participated in Starlight Children's Foundation Great Escapes? Y__ N__
- If your child is older than 7 yrs and under 17, has he/she ever attended a heart camp program at Camp Boggy Creek? Yes ____ No ____

PLEASE CONTINUE ON BACK PAGE

FOR APHH USE ONLY:

Hospital Visit Gifts: MCH JDCH HOLTZ

