



Washington University Medical Center

2011 Holiday Outreach Program



The information will be seen by staff only. All information will remain confidential.

Please Print

*Name: _____

*Family Street Address (no PO Boxes): _____, St. Louis, MO 63110

How long have you lived at this current address: _____ Years _____ Months

*Phone number where family can be contacted: (_____) _____ - _____

*Alternate number: (_____) _____ - _____

Number of children: _____
(Age 0-17)

Number of adults: _____
(Age 18 & up)

Please list each individual name, age, clothing sizes & favorite color (**Please Print**).

*Name	Age	Shirt	Pants	Dress	Shoe	Color
<input type="checkbox"/> Male <input type="checkbox"/> Female		Size	Size	Size	Size	Size

*Name	Age	Shirt	Pants	Dress	Shoe	Color
<input type="checkbox"/> Male <input type="checkbox"/> Female		Size	Size	Size	Size	Size

*Name	Age	Shirt	Pants	Dress	Shoe	Color
<input type="checkbox"/> Male <input type="checkbox"/> Female		Size	Size	Size	Size	Size

*Name	Age	Shirt	Pants	Dress	Shoe	Color
<input type="checkbox"/> Male <input type="checkbox"/> Female		Size	Size	Size	Size	Size

*Name	Age	Shirt	Pants	Dress	Shoe	Color
<input type="checkbox"/> Male <input type="checkbox"/> Female		Size	Size	Size	Size	Size

*Name	Age	Shirt	Pants	Dress	Shoe	Color
<input type="checkbox"/> Male <input type="checkbox"/> Female		Size	Size	Size	Size	Size

Photo Consent

Your consent to the following has no merit in whether you will be accepted into the program.

If accepted into the program, I give permission for my family and me to be photographed and shared with the departments who adopted us through the Holiday Outreach Program.

Yes, I consent to our photo being shared with the department.

No, I do not want our photo shared with the department.

Program Consent

I acknowledge that my family is an applicant for the Holiday Outreach Program and is aware that there are a limited number of families the program serves and therefore may not be selected for this year's program. If selected, the Holiday Outreach Committee has the right to withhold any gifts if it is shown that any of the provided information is misleading.

***Applicant Signature:** _____ **Date:** _____

There are a limited number of spaces available. A completed and accepted application form does not guarantee participation in the program. Gifts received by this program are up to the discretion of the donor. Washington University Medical Center and its affiliates assume no responsibilities as to the quality and quantity of the gifts and donations provided by the donors.

For questions or comments please call Jaime Evans at (314) 747-2331.

Please submit completed application by fax to (314) 371-4283
or send to 4400 Chouteau, St. Louis Mo. 63110

Applications must be submitted by no later than November 4, 2011
Notification letters will be sent out by November 11th

For Office Use Only, Please Do Not Write Below this Line

Received by: _____ Date: _____ Accepted Hold Rejected

Family Number 2011- _____

Type of Assistance Given: (Check all that apply) Gifts Food Utility

