Application for Assistance

Child's birth date (Must be under age 18): Today's date:

Child's Name:

Address:

Phone:

Email:

Name/relationship of person completing this form:

What are the supplies that the child needs? Please be specific (i.e., type of insulin, syringes, blood glucose test strips, etc.)

Please describe the situation that has caused this child to need emergency assistance:

When will your current supplies run out? (i.e., do you have insulin and blood glucose testing supplies now and how long will they last?)

Parent Signature and Date Physician Signature and Date

Physician: ***Please attach original prescriptions for above supplies.***

Mail to: Supplies for CWD c/o Ann Bond, 433 Micol Rd., Pembroke, NH 03275