

KIDS FOR A CURE CLUB  
MEMBERSHIP FORM

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_

Telephone \_\_\_\_\_

Parental Email Address \_\_\_\_\_

Birthday \_\_\_\_\_

I am interested in the KIDS FOR A CURE CLUB because:

I have been diagnosed with \_\_\_\_\_

I have a friend diagnosed with \_\_\_\_\_

I have a family member diagnosed with \_\_\_\_\_

Just Because \_\_\_\_\_

Would you like to receive Kids for a Cure Club Fundraising Get-Started! Packet?

YES NO (circle one)

I give permission for my son/daughter \_\_\_\_\_ to

participate in the American Syringomyelia & Chiari Alliance Project "KIDS FOR A CURE CLUB".

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

Return completed form to:

ASAP, Inc  
PO Box 1586  
Longview TX 75606-1586