My Sisters' Kids
Peer-Support for Grieving Children

4mysisterskids@gmail.com
(609) 364.8320

MY SISTERS' KIDS INTAKE FORM

YOUR NAME: _____ **DATE:**_____

RELATIONSHIP TO CHILD/TEEN/YOUNG ADULT: _____

GUARDIAN/PARENT(S) NAMES: _____

ADDRESS: _____

CITY: _____ **ZIP:** _____

COUNTY: • **Atlantic** • **Gloucester** • **Salem** • **Camden** • **Cumberland** • **Cape May**

PHONES: (Home) _____ **(Work)** _____

(Cell) _____ **(EMAIL)** _____

CHILDREN/TEEN/YOUNG ADULTS who will be attending:

NAME (First & Last)	M/F	AGE	BIRTHDAY

The person who died was the child(ren)'s_____

Date of death: _____ Cause of death: _____

How did you hear about us (or) who referred you? _____

Please note any special considerations for the child(ren), such as allergies or physical/mental challenges:

For Official Use Only

Follow up: (include dates, phone contacts, referrals, etc.)

ORIENTATION DATE (S):
_____

Please return this form to My Sisters' Kids, 1800 E. Broad St., Millville, NJ 08332 Thanks!