

The Christian James Lapp Foundation Child Referral Application

Dedicated to Improving the Quality of Life for Disabled Children & Their Families

Child's Name:

Child's Address:

Child's Phone Number:

Child's BirthDate:

Child's Medical Condition:

Child's Primary/Current Need:

Child's Primary Physician:

Child's Therapists: (if applicable)

Child's Parent/Guardian Name:

This Child Referral Application is for review for the board members of The Christian James Lapp Foundation. I understand that this application does not guarantee the request to be granted.

Signed by Child's Parent/Guardian: _____ Date: _____