Down Syndrome Association of Central New Jersey

# WELCOME AND CONGRATULATIONS
## We Look Forward to Meeting Your Family

DSACNJ is a not-for-profit organization made up of parents, professionals and other supporters of people with Down syndrome. DSACNJ services parents, educators, healthcare professionals, people with Down syndrome and the community at large. We offer social events, support, education, enrichment, and advocacy for children and adults with Down Syndrome and their families.

DSACNJ Parents' First Call program offers a connection to another parent and introduces you to our group. Our First Call parents are an invaluable source of information and support. DSACNJ also offers a welcome packet with helpful information.

Due to privacy concerns, the doctor cannot share your information with DSACNJ without your permission. If you would like to connect with us, please complete the following information:

I grant permission to _____ (physician's office) to release my name, address, phone number and baby's name and date of birth to the Down Syndrome Association of Central New Jersey so that I may be contacted. I authorize such contact by DSACNJ. **No medical information will be released.** Only your name and contact information will be shared as below.

I hereby release _____ (Physician's Office or Hospital), DSACNJ and their employees from any and all liability for any and all such claims or damages which may at any time result on account of compliance with this authorization.

I also acknowledge that I am the parent or legal guardian of this baby/child. I request (please check all that apply):

☐ To be added to the DSACNJ mailing list and have the parent welcome packet mailed to me

☐ A phone call from a DSACNJ First Call mom

☐ A phone call from a DSACNJ First Call dad

☐ A phone call from a Spanish-speaking First Call parent

**Signature: _____ Date: _____**

Name (please print)_____
Address (street, city/town, state, zip):_____
_____
Home phone: _____Cell phone: _____
E-mail: _____
Child's name: _____ Child's Date of Birth_____

To Physician's Office - For the most rapid response, please call with the above information on your patient's behalf or e-mail a copy of this form to:

180 Ewingville Road
Ewing, NJ 08638
(866) 369-6796

dsacnj@arcmercer.org