



GO BABY GO APPLICATION

Today's Date: _____

Please enter your Child's information below.

CHILD'S NAME _____
(First) (Last)

BIRTH DATE _____ MEDICAL DIAGNOSIS _____
(Month) (Day) (Year)

HEIGHT (Inches) _____ WEIGHT (lbs) _____

Please list any known allergies:

Please list any current medical equipment, if any:

Please list child's strengths:

Please list child's challenges:

Primary means of mobility:

Can child sit unsupported for 10-15 minutes? ☐ Yes ☐ No

Does your child have any visual limitations? ☐ Yes ☐ No

If YES, please explain:

Can your child hold his/her head up by himself/herself? ☐ Yes ☐ No

Can your child use two hands to hold a toy? ☐ Yes ☐ No

Does your child receive services at LifeScape? ☐ Yes ☐ No



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Please enter Parent/Guardian information below.

PARENT/GUARDIAN NAME _____

EMAIL ADDRESS _____

MAILING ADDRESS _____
(Street) (City) (State) (Zip)

PHONE NUMBER _____ (Be sure to include area code)

SIGNATURES

NAME _____

RELATIONSHIP _____

PARENT/GUARDIAN SIGNATURE _____

DATE _____

Please mail or email completed application to:

LifeScape
Attn: Jodi Stowell
1020 West 18th Street
Sioux Falls, SD 57104

Email: Jodi.Stowell@LifeScapeSD.org