The Randolph B. Capone Cleft Lip and Palate Program

BUDDY PROGRAM APPLICATION

Child's Name

Child's Age

Child's Birthdate

Child's Gender

Parent/Guardian/Caregivers Name(s)

Phone Number (Please provide only if you are willing to be contacted by assigned Buddy or family)

Email Address (Please provide only if you are willing to be contacted by assigned Buddy or family)

County of Residence

How would you describe your child's personality? Please list some of your child's interests:

Do you have any special requests or are accommodations needed?

What are you hoping to gain from the Cleft Lip and Palate Team Buddy Program?

Would you be willing to have your child participate in a video chat with his or her Buddy?

Yes No

PLEASE MAIL OR EMAIL YOUR COMPLETED FORMS TO:

Stephanie Boblooch, Cleft Program
6535 N. Charles St., Suite 250, Baltimore, MD 21204
Sboblooch@gbmc.org

GBMC