



Gabriel's Closet

a Catholic Charities of North Louisiana Program

First Name _____ Last Name _____

Phone (s) _____ Street Address _____

City _____ State _____ Zip Code _____

Due Date: _____ Physician _____ Phone#: _____ Insurance Y/N: _____

Adults:	Sex: M/F	DOB	Children:	Sex: M/F	DOB

Do you have a pediatrician? _____ Are you receiving assistance from any other agencies? _____
If so, which? _____

Will you be receiving WIC assistance _____ Are you interested in Infant Care classes _____

What specific needs or concerns do you have for you and your infant now? _____

What is your household income? \$ _____ From what source? _____

Do you receive Food Stamps? _____ \$ _____ Do you plan to breast feed _____

NOTES: _____

****If you need assistance from Gabriel's Closet in the future, you must complete a class first. Please call us for class schedules.***

****We ask that as a recipient of items from Gabriel's Closet, you take good care of them and plan to return them to the closet when you no longer need them, to share with other mothers in need.***

****Catholic Charities of North Louisiana is not responsible for any injuries while using items donated by Gabriel's Closet.***

I, (please print name) _____ shall not hold Catholic Charities of North Louisiana or the Diocese of Shreveport liable for any injury incurred while using items donated to me and my infant through Gabriel's Closet.

Signature: _____ Date: _____

Witness: _____ Date: _____