

Membership

Kim Ward

We welcome all mothers and “mothers-to-be” of multiples to any of our meetings or planned events. If you wish to join, please complete the membership form below and attach annual membership dues of \$40 which includes membership to local, state and national organizations. Please bring the completed form AND your dues to our next meeting or mail your completed form AND a check (made to NPMOM) to:

Kim Ward
2420 Wedgewood Drive
Wexford, PA 15090



North Pittsburgh Mothers of Multiples

Membership Form

PLEASE COMPLETE USING MS WORD OR PRINT CLEARLY

Personal Information

Name _____ Birth Date: _____ / _____ (Month/Day format)

Spouse's Name _____ Birth Date: _____ / _____ Anniversary _____ / _____

Address _____ E-mail Address: _____

City, State Zip _____ Home Phone: _____

Do you work outside the Home? Yes No If yes, work phone: _____

Do you work FROM home? Yes No Occupation: _____

Occupation before children _____ Spouses Occupation _____

How did you hear about NPMOM? _____

Reason for joining NPMOMs? _____

(Types: Identical, Fraternal, Not sure, Singleton)

Children's Information

Name	Birthdate	Gender	Multiple	Type	Notes
	/ /	M F	Y N	I F N S	
	/ /	M F	Y N	I F N S	
	/ /	M F	Y N	I F N S	
	/ /	M F	Y N	I F N S	
	/ /	M F	Y N	I F N S	
	/ /	M F	Y N	I F N S	
	/ /	M F	Y N	I F N S	

Are you currently expecting? How many? _____ Sex(s) (if known): _____ Due Date: _____
 Would you like to be included in our Big Sister / Little Sister program? (Yes/No) _____

Please make check payable to NPMOM. Bring your check and form (if completed on paper) to the meeting or mail to:
 Kimberly Ward
 2420 Wedgewood Drive
 Wexford, PA 15090

Visit our NPMOM website: www.npmoms.org



North Pittsburgh Mothers of Multiples

Member Information & Support

For information and support purposes, please provide information regarding your pregnancy and your children. Please note, your privacy is important to us. Information collected here is for NPMOM use in determining demographics, interests, and providing support to members. Information is used exclusively for NPMOM, and will not be sold or shared outside of the Mothers of Multiples.

For member support purposes, Are you willing to talk with other members about these conditions? If yes, please check the second box (in addition to the first) for each condition.

Your name: _____

SAMPLE:

Check here if have →

Condition

check here if willing to talk with other members about your experiences

Children

<input type="checkbox"/> Asthma <input type="checkbox"/>	<input type="checkbox"/> Heart Murmur PDA <input type="checkbox"/>	<input type="checkbox"/> Perinatal / Infant Loss <input type="checkbox"/>	Please List Other Conditions: _____ _____ _____ _____ _____
<input type="checkbox"/> Blindness <input type="checkbox"/>	<input type="checkbox"/> Heart Murmur VSD <input type="checkbox"/>	<input type="checkbox"/> Reflux <input type="checkbox"/>	
<input type="checkbox"/> Cerebral Palsy <input type="checkbox"/>	<input type="checkbox"/> Home monitors <input type="checkbox"/>	<input type="checkbox"/> Speech <input type="checkbox"/>	
<input type="checkbox"/> Closure of VSD <input type="checkbox"/>	<input type="checkbox"/> Hypospadias <input type="checkbox"/>	<input type="checkbox"/> Tonsillectomy <input type="checkbox"/>	
<input type="checkbox"/> Downs Syndrome <input type="checkbox"/>	<input type="checkbox"/> Jaundice <input type="checkbox"/>	<input type="checkbox"/> Tubes in Ears <input type="checkbox"/>	
<input type="checkbox"/> Feeding Problems <input type="checkbox"/>	<input type="checkbox"/> Jaundice home treatment <input type="checkbox"/>	<input type="checkbox"/> Visual Impairment <input type="checkbox"/>	
<input type="checkbox"/> Feeding Tubes <input type="checkbox"/>	<input type="checkbox"/> Lazy Eye <input type="checkbox"/>	<input type="checkbox"/> Other <input type="checkbox"/>	
<input type="checkbox"/> Food Allergies <input type="checkbox"/>	<input type="checkbox"/> Low Glucose Levels <input type="checkbox"/>		

Pregnancy-Related

<input type="checkbox"/> Anemia <input type="checkbox"/>	<input type="checkbox"/> Post Partum Depression <input type="checkbox"/>	Please List Other Conditions: _____ _____ _____ _____ _____
<input type="checkbox"/> Bed rest <input type="checkbox"/>	<input type="checkbox"/> Pre-Eclamsia <input type="checkbox"/>	
How long? _____	<input type="checkbox"/> Premature Birth <input type="checkbox"/> # of wks _____	
<input type="checkbox"/> Chlomid <input type="checkbox"/>	<input type="checkbox"/> Pre-Term Labor <input type="checkbox"/> # of wks _____	
<input type="checkbox"/> Gestational Diabetes <input type="checkbox"/>	<input type="checkbox"/> Reflux <input type="checkbox"/>	
<input type="checkbox"/> IUI <input type="checkbox"/>	<input type="checkbox"/> Terbutaline <input type="checkbox"/>	
<input type="checkbox"/> IVF <input type="checkbox"/>	<input type="checkbox"/> Twin-to-Twin Transfusion <input type="checkbox"/>	
<input type="checkbox"/> Ovarian Thrombosis <input type="checkbox"/>	<input type="checkbox"/> Vanishing Twin Syndrome <input type="checkbox"/>	
<input type="checkbox"/> Polycystic Ovaries <input type="checkbox"/>	<input type="checkbox"/> Other <input type="checkbox"/>	If not premature, # Weeks at delivery: _____ _____ _____

Other Support / Discussion Topics you have experience with and would be willing to be an "expert" for:

<input type="checkbox"/> Breast Feeding <input type="checkbox"/>	<input type="checkbox"/> Home Schooling <input type="checkbox"/>	<input type="checkbox"/> Potty Training <input type="checkbox"/>	<input type="checkbox"/> Traveling with Kids <input type="checkbox"/>
<input type="checkbox"/> Breast Pumping <input type="checkbox"/>	<input type="checkbox"/> Infertility Issues <input type="checkbox"/>	<input type="checkbox"/> Safety Devices <input type="checkbox"/>	<input type="checkbox"/> Triplet Mom <input type="checkbox"/>
<input type="checkbox"/> Camping with <input type="checkbox"/>	<input type="checkbox"/> Kids close in Age <input type="checkbox"/>	<input type="checkbox"/> Single Parent <input type="checkbox"/>	<input type="checkbox"/> Working-from-Home <input type="checkbox"/>
<input type="checkbox"/> Cloth Diapers <input type="checkbox"/>	<input type="checkbox"/> Large Family <input type="checkbox"/>	<input type="checkbox"/> Stay-at-Home Dad <input type="checkbox"/>	<input type="checkbox"/> Working-outside-home <input type="checkbox"/>
<input type="checkbox"/> Divorce Recovery <input type="checkbox"/>	<input type="checkbox"/> Moving with Kids <input type="checkbox"/>	<input type="checkbox"/> Stay-at-Home Mom <input type="checkbox"/>	<input type="checkbox"/> Other <input type="checkbox"/> (list other topics on reverse)

Additional Notes or comments:



North Pittsburgh Mothers of Multiples

Information provided here is a fun get-to-know-you sheet. Information may be used in the newsletter or on the website.

Name:

Hometown:

College:

Special Interests:

How I spent my time before becoming a Mom:

How my husband & I met:

Something I am looking forward to:

What I learned upon becoming a Mother of Multiples:

How would you spend an entire day to yourself?

Our reactions when we found out we were having multiples:

How have I become like my Mother:

A little known fact about myself:

Best advice you were given:

The nicest thing someone has said to me regarding my multiples:

My favorite twin/triplet or more story:

Reason for joining NPMOM:
