My First Steps began at......
Mobridge Regional Hospital

*Child's Name:*________________

*Date of Birth:*________________

*Parent's Name:*_______________

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*Address:*____________________

____

This is a gift from

*Name:*______________________

*Address:*____________________

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The parents will be notified of your gift.

Please complete the following information and mail it, along with your $25.00 donation to:

Mobridge Regional Health Care Foundation

1401 10th Ave West

Mobridge, SD 57601