



Celiac Support Group

Children's Hospital, Boston

Registration Form

Date: _____

Parents' Names: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

E-Mail address: _____

Child's Name: _____

Date of Birth: _____ Date Diagnosed: _____

Associated Medical Problems, such as *Diabetes* or *Down Syndrome* (Optional): _____

Other Food Intolerances: _____

Other Family Members with Celiac Disease (Optional): _____

Please check items of interest to you:

- I would like to receive quarterly newsletters.
- I would like to receive announcements of meeting and special events.
- I would like to be contacted by the outreach committee for newly diagnosed children.

- I would be willing to have the above information shared with other support group members. If you check this item, please read the following information and sign below.

I am aware that the Support Group cannot control how the recipient uses or shares the information, and the laws protecting its confidentiality at Children's Hospital may or may not protect this information once it has been disclosed to the recipient. This authorization will expire when I stop participating in the Support Group. Information will not be released without a valid signature below. I can, however, cancel this authorization in writing at any time by contacting the Support Group at the address below.

Signature of Parent **or Child if 18 or older**: _____

The suggested annual donation for registration is \$35. (Note: Registration may be waived in the event of financial hardship.)

Additional Contributions:

- Benefactor \$500 Sponsor \$250 Friend \$100 Donor \$50 Other _____
- Check here if your company has a matching gift program. Include appropriate forms.

Please make checks payable to "Celiac Support Group, Children's Hospital".

Mail completed form and donation to:	DUES \$	35.
	ADDITIONAL \$	_____
	TOTAL \$	_____

CELIAC SUPPORT GROUP
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