



# Celiac Support Group

Children's Hospital, Boston

## Registration Form

Date: \_\_\_\_\_

Parents' Names: \_\_\_\_\_

Address: \_\_\_\_\_

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: \_\_\_\_\_

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 \$30. (Membership may be waived in the event of

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Signature of Parent or Child if 18 or older: \_\_\_\_\_

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 \$ **30.**  
ADDITIONAL \$ \_\_\_\_\_

**CELIAC SUPPORT GROUP** TOTAL \$ \_\_\_\_\_  
**CHILDREN'S HOSPITAL- GI / NUTRITION DEPT.**  
**300 LONGWOOD AVE., BOSTON, MA 02115**  
**PHONE 617-355-2127**

REVISED 9/05



Children's Hospital Boston