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 annual fee for family membership is **$35**. (Note: If temporary financial difficulties prevent you from paying the suggested amount, please join anyway. You may make a contribution of any size, or even none at all. When your financial picture improves, please be generous.)

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".

DUES $ 35.00
ADDITIONAL $ _____
TOTAL $ _____

Mail completed form and donation to:

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

REVISED 11/08