



Celiac Support Group Registration Form

Parents' Names:		
Address:		
	State:	Zip:
Telephone:	E-Mail address:	
Child's Name:		
Date of Birth:	Date Diagnosed:	
Associated Medical Problems, su	uch as <i>Diabetes</i> or <i>Down Syndrome</i> (Option	nal):
Other Food Intolerances:		
Other Family Members with Celia	ac Disease (Optional):	
Please check items of interest	to you:	
☐ 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.		
If you check the following item	n, please read the information and sign be	elow:
☐ I would be willing to have the child's name.	above information shared with other suppor	rt group members, excluding
its confidentiality at Boston Childi recipient. This authorization will	up cannot control how the recipient uses or share ren's Hospital may or may not protect this inform expire when I stop participating in the Support G. I can, however, cancel this authorization in writin	ration once it has been disclosed to the roup. Information will not be released
Signature of Parent or Child if	18 or older:	Date:
Relationship to Child:		
suggested amount, please go to	ership is \$35 . (Note: If temporary financial d www.childrenshospital.org/celiac, Celiac Sung Celiac Sung Celiac Support Group Fee" form and retu	upport Group → Join Support Group.
☐ Benefactor: \$500 ☐ Spo	nsor: \$250	or: \$50
☐ Check here if your company	has a matching gift program. Include appro	opriate forms.
Please make checks payable to 'Mail completed form and paymer	"Celiac Support Group, Boston Children's H nt to:	lospital."
CELIAC SUPPO BOSTON CHILE	ORT GROUP OREN'S HOSPITAL – GI/NUTRITION	

Please contact <u>celiacsupportgroup@childrens.harvard.edu</u> or call 617-355-2127 with any questions!

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