Membership Form

Parents' Names: ____

Address: ____

City: ______________________ State: ____________ Zip: ____________

Telephone: ____________________ E-Mail address: ____________________

Child's Name: ______________________________ Gender: ______________

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): ______________________________

Physician and hospital affiliation: ____

Within the past 12 months we worried whether our food would run out before we got money to buy more.

_____ Often True _____ Sometimes True _____Never True _____ Don't Know _____ Decline to Answer

Within the past 12 months the food we bought just didn't last and we didn't have money to get more.

_____ Often True _____ Sometimes True _____ Never True _____ Don't Know _____ Decline to Answer

If you check the following item, please read the information and sign below:

☐ I would be willing to have the above information shared with other support group members, excluding child's name.

I am aware that Celiac Kids Connection cannot control how the recipient uses or shares the information, and the laws protecting its confidentiality at Boston 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 Celiac Kids Connection. Information will not be released without a valid signature below. I can, however, cancel this authorization in writing at any time by contacting Celiac Kids Connection at the address below.

Signature of Parent or Child if 18 or older: ______________________________ **Date**: ____________

Relationship to Child: ____

The annual fee for family membership is **$35**. Discounts are available for multi-year options. Choose One:

☐ Recurring: $35 ☐ One Year: $35 ☐ Two Year: $60 ☐ Five Year: $150 ☐ Ten Year: $250

Note: If temporary financial difficulties prevent you from paying the suggested amount please download and return this form (http://ow.ly/ttlP309l7Wm) with your registration.

Please make checks payable to "Celiac Support Group" Mail completed form and payment to:

CELIAC KIDS CONNECTION
BOSTON CHILDREN'S HOSPITAL – GI/NUTRITION
300 LONGWOOD AVENUE
BOSTON, MA 02115

Please contact celiackidsconnection@childrens.harvard.edu or call 617-355-2127 with any questions!

Boston Children's Hospital
Where the world comes for answers

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