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): ____________________

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Other Food Intolerances: ______________________________

Other Family Members with Celiac Disease (Optional): ______________________________

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Please check items of interest to you:

☐ Celiac Kids Connections sends announcements of meetings and special events. Check to opt out of receiving e-mails.

☐ I would like to be contacted by the outreach committee for newly diagnosed children.

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 muli-year options. Choose One:

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

(Note: If temporary financial difficulties prevent you from paying the suggested amount, visit http://www.celiackidsconnection.org/wp-content/uploads/2017/02/CKC-Financial-Assistance.pdf

Additional Contributions:

Benefactor: $500 Sponsor: $250 Friend: $100 Donor: $50 Other amount $______

Check here if your company has a matching gift program. Include appropriate forms.

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
Until every child is well™

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