REGISTRATION & PRIMARY CONTACT INFORMATION

INFUSION U SELF-INFUSION INSTRUCTION PROGRAM • PROGRAM APPLICATION

Name ________________________________ **Date of Birth:** ________ **Age (at the time of start):** ________

Name child prefers to be called (if different): ____

Diagnosis: ____

Prophylaxis treatment product and schedule: ____

____

Treatment required for bleeding episodes: ____

____

Parent/Guardian/Primary Contact: ____

Mailing Address: ____

City: ____________________ State: ________________ Zip Code: ________________

Home Phone: _____ - ______ - ______ Work/Cell Phone: _____ - ______ - ______ ext ______

Email address: ____

Best way to contact you? (circle one) Home Phone Cell Phone Email Work Phone

EMERGENCY CONTACTS

First Contact's Name: ____________________________ Relationship: ____________________

Home Phone: _____ - ______ - ______ Work/Cell Phone: _____ - ______ - ______ ext ______

Second Contact's Name: ____________________________ Relationship: ____________________

Home Phone: _____ - ______ - ______ Work/Cell Phone: _____ - ______ - ______ ext ______

SAFETY INFORMATION (please list all known conditions so we can accommodate your child's needs)

Does your child have any medical conditions, allergies including food allergies or special needs?

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I verify that all the information I have provided in this document is true to the best of my knowledge.

X ____

Parent/Guardian Signature and Date