

THE COALITION FOR HEMOPHILIA B, INC.



BABYSITTING REGISTRATION FORM

Name of Child: _____ Age: _____

Please list ALL medical conditions and include ALL medications (including FACTOR) as well as any other information necessary to ensure your child's safety (i.e., special needs, allergies, etc.)

Parent (s) Name:

Cell Phone:

Please list activities, movies, and games your child enjoys, as well as anything he or she may be afraid of. Also, please let us know what your child likes to eat for lunch, snacks, and beverages.

825 THIRD AVENUE, SUITE 226, NEW YORK, NY 10022

Tel: (212) 520 - 8272

E-mail: hemob@ix.netcom.com

Fax: (212) 520 - 8501

www.coalitionforhemophiliab.org