

Good Grief Day Registration Form

Child's Name _____

Child's Nickname _____ Child's Age _____

Parent's/Guardian's Name _____

Street Address _____

City _____ State _____ Zip _____

Phone:

Home(____) _____ Work(____) _____ Cell(____) _____

Date that loss occurred _____ Who Died/Relationship _____

Emergency Contact (the name and contact information of someone who will be available during the Good Grief Day activities on 7/17/2010 from 8:00AM until 2PM)

Name _____ Relationship _____

Address _____

Phone: Home(____) _____ Cell(____) _____

Health Information:

Does your child have any health/behavioral/learning concerns?

Your child's medications (name and dose) _____

Child's Physician _____ Phone: _____

Hospital of Choice: _____

Allergies (both food and drug) _____

Child T-Shirt Size _____ S(6-8) _____ M(10-12) _____ L(14-16)

Adult _____ S _____ M _____ L _____ XL

I would like to attend the Parent/Caregiver's meeting from 1 to 1:45PM ____ Yes ____ No

Please return this form to STHPC at 11751 East Corning Rd, Corning, NY 14830