



REGISTRATION FORM

Name: _____ Age: _____

Relation to Person with Bleeding Disorder (i.e., Self, Mother, etc.) _____

Name of Family Members attending, Relation to Person with Bleeding Disorder, and Age:

_____	Age _____
_____	Age _____
_____	Age _____
_____	Age _____
_____	Age _____

Which member(s) of your family have Hemophilia B?

_____	Age _____
_____	Age _____

(Please note if person has inhibitors)

Contact Information

Telephone: _____ Cell phone: _____

E-mail: _____

Emergency Contact:

Name: _____ Phone: _____

Photo Release

Do you authorize the use of any photographs that include yourself or family members (to be used for our newsletter, website)? _____ YES _____ NO