REGISTRATION FORM

Please answer all questions

FLORIDA HEMOPHILIA ASSOCIATION
for all bleeding disorders

FHA 34th Annual Family Education Symposium

August 3 - 6, 2017

Embassy Suites by Hilton
West Palm Beach Central
1601 Belvedere Rd.,
West Palm Beach, FL 33406

ATTENDEE INFORMATION

❑ Dr. ❑ Mr. ❑ Mrs. ❑ Ms.

First Name *Initial* *Last Name* *Suffix (i.e., Jr, Sr)*

Mailing Address (Indicate: ❑ Home ❑ Business)

City *State* *Zip Code* *Country*

E-Mail Address

Home Phone Number *Mobile Number* *Your Occupation/Company Name*

Please print clearly or type and complete a registration form for each adult.
Feel free to duplicate this form if necessary.

Is this your first FHA annual meeting? ❑ Yes ❑ No

Please complete the following information
(Note: Your information is confidential and can help us to plan/develop new programs for your benefit)

Select One:

A. Consumer ❑ Person with a bleeding disorder ❑ Family member of a person with a bleeding disorder
Type of disorder: ❑ Hemophilia A ❑ Hemophilia B ❑ VWD
❑ Other _____

B. Provider ❑ Physician ❑ Nurse ❑ Social Worker ❑ Physical Therapist
❑ Other _____

Gender ❑ M ❑ F Date of Birth _____

Racial/Ethnic Background: ❑ Caucasian ❑ African-American ❑ Hispanic ❑ Asian/Pacific Islander
❑ Native American ❑ Other _____

REGISTRATION
You must submit your registration by **June 13**, 2017.

$60 Family of 4 *(Immediate Family)*
$5 Each Additional Child *(Immediate Family)*

Total Amount Enclosed Total $ _____

I WILL BE CHECKING IN ON ❑ Thur. 8/3 ❑ Fri 8/4 **AND CHECKING OUT** ❑ Sun. 8/6

❑ METHOD OF PAYMENT: (check one) ❑ Check ❑ Money Order ❑ Paypal

Make checks or money orders payable to: Florida Hemophilia Association
Please send check or money order for registration fees.

ROOM GUARANTEE: Please include credit card information for room guarantee only. Your credit card will only be charged if you do not cancel your reservation with FHA by July 31st.

Room Guarantee Credit Card Information: ❑ MasterCard ❑ Visa ❑ Discover ❑ American Express

CC# _____ Exp. Date: _____

_____
SIGNATURE

Registration for FHA's Annual Meeting and it's Program for Kids/Teens implies consent that any pictures, video, audio taping during the meeting program and FHA-related events can be used by FHA for Annual Meeting coverage and for promotional purposes. Please notify FHA if you do not want your child's picture used.

What is the name of your Homecare Company?

_____

List the medications and manufacturers of the bleeding disorder products your family uses.

_____

Name of Hemophilia treatment center (HTC) and/or Hematologist?

_____

Indicate which of the following programs you are on, if any.
❑ Healthy Kids ❑ Medicaid ❑ CMS
❑ Medicare ❑ Other_____
❑ Private Insurance
Insurance Carrier:_____

Attendance at all meetings is mandatory and is required to satisfy event rules.

MAIL FORM TO:
Florida Hemophilia Association
Attn: Debbi Adamkin
915 Middle River Drive, Suite 421
Fort Lauderdale, FL 33304
Tel: 305-235-0717
Fax: 954-900-5149

REGISTRATION FORM for KIDS and TEENS

Please answer all questions

FLORIDA HEMOPHILIA ASSOCIATION
for all bleeding disorders

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NOTE: Please print clearly or type and complete a registration form for each child.
Feel free to duplicate this form as necessary.

ATTENDEE INFORMATION

_____
Child's Name

_____
City *State* *Zip Code* *Country*

_____
Gender: ❑ *M* ❑ *F*

_____
Date of Birth (MM/DD/YYYY) *Age at time of meeting*

_____
❑ *Dr.* ❑ *Mr.* ❑ *Mrs.* ❑ *Ms.*

_____
Parent/Guardian Attending Meeting (First and Last Name) *Relationship to Child*

_____
Daytime Phone Number (Including Area Code)

_____
*Parent's/Guardian's Pager or Cellular Number (to reach you onsite in case of emergency—**required**)*

Will your child be attending the Kids or Teen Program? ❑ *Yes* ❑ *No*

If yes, please check the appropriate box below

❑ **Program for Kids: ages 0-6 years**

❑ **Program for Older Kids: ages 7-12 years**

❑ **Program for Teenagers: ages 13+ years**

NOTE: THERE IS NO ONSITE REGISTRATION FOR THIS PROGRAM.

IMPORTANT INFORMATION

Please complete the following information
(Note: Your information is confidential and can help us to plan/develop new programs for your benefit)

Consumer: ❑ Person with a bleeding disorder ❑ Family member of a person with a bleeding disorder

Type of Disorder: ❑ Hemophilia A ❑ Hemophilia B ❑ VWD ❑ Other _____

Racial/Ethnic ❑ Causacian ❑ African-American ❑ Hispanic ❑ Asian Pacific Islander

Background: ❑ Native American ❑ Other _____

Does your child have any medical problems, allergies, limiting disabilities, or is s/he taking any medications (prescribed or otherwise)? ❑ Yes ❑ No If yes, please explain (FHA employees cannot administer medication to program participants)

Release of Liability
I understand that parts of the FHA annual meeting Program for Kids/Teens may be physically demanding. I affirm that my child's health is good and that s/he is not under a physician's care for any undisclosed condition that might endanger his/her health or that of other participants. I understand that each participant assumes the risk of possible injury, loss, or damage during participation. In the event of an emergency, I understand that an effort will be made to contact me. I also agree to remain on premises (at the hotel) during the Program. If contact is impossible, I give permission for emergency medical attention, including treatment as recommended by an attending physician, to be administered to my child. I understand that I am responsible for any medical cost.

_____
Parent/Guardian Signature Date

Registrations for Kids/Teens must be submitted by June 13, 2017

There is no onsite registration for this program.

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