CHC Family Member

Please complete and return as soon as possible to: Children with Chronic Health Conditions, (CHC) P.O. Box 1437-Slot S380, Little Rock, AR 72203-1437. Attn: Parent Consultant

I hereby give CHC permission to release my name, address, and phone number to the Parent Advisory Council Inc. for the purpose of informing me of legislative issues, health care issues, parent support group meetings, and other issues concerning my child. If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act (ADA) Coordinator at (501) 682-1461 and 1-800-482-5850, ext. 22277 (voice) or (501) 682-6789 and 1-877-708-8191 (TDD).

PLEASE PRINT

Name of Child: _____

Child's Age: _____

Name of Parent/Guardian: _____

Address: _____

City, State, Zip: _____

County of Residence: _____

Telephone Number: _____

E-mail: _____

Signature of Parent/Guardian: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Languages spoken in the home other than English: _____

School District/Affiliation : _____

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM.