

**SIBLING CLASS
REGISTRATION**

PRE-REGISTRATION REQUIRED

Community Health Outreach

Parents' names: _____

Address: _____

Phone: _____ day or evening (please circle)

Your Doctor/Midwife _____ email _____

Baby's Due Date: _____

Will the baby be breastfed or bottlefed? (please circle)

Names and ages of siblings: _____

Is there anything we should know about your child?

Typical class time is 10:00 am on certain Saturdays

Other times/days available by appointment

The fee for this class is **\$10** per child; maximum **\$20** per family.

We serve juice and cookies at class, without artificial sweetening. May your child have cookies and juice?

yes or no (please circle)

Parent/Guardian: _____ Date: _____

Signature

Please Mail or Fax: Community Health Outreach
Porter Hospital, Inc.
115 Porter Drive
Middlebury, Vermont 05753

FAX # (802) 388-8858
PHONE # (802) 382-3413
PorterMedical.org/outreach.html