

In Touch Registration Form

Class registering for _____

Class month/day/time _____

Parent's name _____ Parent's name _____

Baby's name _____ DOB _____ Due date _____

Address _____ Zip _____

E-mail address _____

Phone numbers _____

Is your baby under care of a physician? ___ Name of Dr _____

Dr phone number _____ Reason for care _____

Is your baby taking any medication? _____

Does your baby have any conditions such as: heart ___ circulatory ___ hip ___ hernia ___

skin ___ jaundice ___ other _____

Do you have any concerns such as: sleeping patterns ___ colic ___ feeding challenges ___

weight gain ___ other/explain _____

Signature or name of person completing this form _____

Date _____

Mail completed registration form and your check to:
Women's Health Center @ SHMC, W 101 8th Ave., Spokane, WA 99204

The information and procedures in this class should not substitute the advice of a personal physician, medical practitioner or other trained health care professional.
All participants should consult with their healthcare provider before taking any of the actions recommended.