Registration and Consent Form

*** Please Complete in Ink***

Mother's Last Name: _____ First: _____MI:__

Mother's Date of Birth: _____ Occupation: _____

Other Parent's Last Name: _____ First: _____ MI:__

Other Parent's Date of Birth: _____ Occupation: _____

Phone: Mother: _____ Other Parent: _____

E-mail: _____

Baby's Last Name_____ First name: _____ M F

Date of Birth: _____ Birth weight: _____lb _____ oz

Discharge Date: _____ Discharge Wt: _____lb _____ oz

Recent weight: _____lb. _____oz Date:_____

Address: _____

City, State, Zip Code _____

Baby's Pediatric Provider: _____

City, State _____

Phone:_____ FAX:_____

Mother's OB Provider: _____

City, State _____

Phone:_____ FAX:_____

Mother's Insurance Plan _____

Policy Group Number_____ Insured's ID Number_____

Baby's Insurance Plan _____

Policy Group Number_____ Insured's ID Number_____

I grant my consent to Gale N. Touger, APRN, IBCLC to observe me breastfeeding, to examine my breasts, and to observe and examine my baby during the period of lactation assistance. I understand that all medical care is to be provided by my/our own physician(s).

I grant permission to Carolina Lactation Consultants, LLC to share pertinent information about this consultation with my/our health care providers, the referral source, my community breastfeeding helper, my insurance company and as appropriate to further the knowledge of breastfeeding.

_____

Signature of Mother Date

_____

Signature of IBCLC Date