

# Lucile Packard Children's Hospital Perinatal Education Program Registration Form

Name \_\_\_\_\_  
Last First

Name of Partner \_\_\_\_\_

Name/Age of Sibling (for Sibling Class) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone(\_\_\_\_) \_\_\_\_\_ Work Phone(\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Due date Obstetrician or Midwife Name Hospital



*Note: Please inform registrar if you have special needs.*

Class Title	Class Start Date	Fee
	<small>1<sup>st</sup> choice/2<sup>nd</sup> choice</small>	

**Credit Card:** \_\_\_\_\_ MasterCard \_\_\_\_\_ Visa \_\_\_\_\_ Discover  
 Card number \_\_\_\_\_ Expiration date \_\_\_\_\_  
 Card holder \_\_\_\_\_ Amount of Payment \$ \_\_\_\_\_  
 Signature \_\_\_\_\_

**Please make checks payable to: LPCH**  
**Mail to: Perinatal Education, Room P156** **or FAX to: (650) 724-7514**  
 Lucile Packard Children's Hospital  
 725 Welch Road  
 Palo Alto, CA 94306

**A confirmation letter with map and receipt for payment will be sent upon registration.**