NEWTON: 1ST WED OF MONTH
DECEMBER 2ND - MARCH 2ND 7-8PM

FRAMINGHAM: 1ST THURS OF MONTH
DECEMBER 3RD – MARCH 3RD 7-8PM

YOUR CHILD'S WEIGHT: HELPING WITHOUT HARMING

Have you received concerning information about your child's weight? Join experienced pediatric weight management and eating disorder dietitian, Amy Gardner, MS, RD along with other parents to discover strategies to help support your child's health while allowing them to maintain a positive relationship with food and good self-esteem. Learn how different feeding styles impact eating behaviors. The group will coincide with reading and processing the book by Ellyn Satter, Your Child's Weight: Helping Without Harming. A copy of the book will be provided to registrants at the first session.

metrowest NUTRITION

Gain valuable strategies to support your child in forming a healthy relationship with food and his/her body

1 Night a Month
$50 per session

Led by Registered Dietitian, Amy Gardner, MS, RD

Ideal for parents of kids 13 and under

NEWTON
1400 Centre Street, #207
1st class - Wed, Dec 2nd 7-8pm
617-332-2282 x1

FRAMINGHAM
661 Franklin Street, 1st Fl
1st class – Thurs Dec 3rd 7-8pm
617-332-2282 x1

www.metrowestnutrition.com

metrowest NUTRITION

METROWEST NUTRITION
REGISTRATION FORM

Today's date:	Program Start Date:	PCP/Child's Pediatrician:
Program Registering for:		Total Cost:

CLIENT INFORMATION

Last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	

Include me in newsletter ❑ Yes ❑ No	How did you hear about our program?	Group location ❑ Newton ❑ Framingham	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Other family members seen here:

PAYMENT INFORMATION

If paying with check, please make it out to Metrowest Nutrtion

Check Credit Card (circle one) Check #:_____	Exp. date	Name of Card Holder CSV:
Credit Card Number	Amount Due	I authorize Metrowest Nutrition to make a one-time payment in the amount listed here. (Sign here) _____

Address of card holder (if different):

Patient's relationship to card holder: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance.

_____ _____

Patient/Guardian signature *Date*

Please fax your completed registration form to: 508-302-0507 or email it to amy@metrowestnutrition.com. Thank you!