Revised December 2021

Healing Hearts of Southeast Wisconsin
Registration Form

Child Participants:

1. Name/Nickname:_____
   Sex: ☐ Male ☐ Female
   DOB: _____
   Age: _____
   Grade: _____
   School: _____
   Any Medical Conditions or
   Allergies?: _____
   _____
   _____
   Special Learning Needs?:
   _____
   _____
   _____

2. Name/Nickname:_____
   Sex: ☐ Male ☐ Female
   DOB: _____
   Age: _____
   Grade: _____
   School: _____
   Any Medical Conditions or
   Allergies?: _____
   _____
   _____
   Special Learning Needs?:
   _____
   _____
   _____

3. Name/Nickname:_____
   Sex: ☐ Male ☐ Female
   DOB: _____
   Age: _____
   Grade: _____
   School: _____
   Any Medical Conditions or
   Allergies?: _____
   _____
   _____
   Special Learning Needs?:
   _____
   _____
   _____

4. Name/Nickname:_____
   Sex: ☐ Male ☐ Female
   DOB: _____
   Age: _____
   Grade: _____
   School: _____
   Any Medical Conditions or
   Allergies?: _____
   _____
   _____
   Special Learning Needs?:
   _____
   _____
   _____

Our Mission: Healing Hearts of Southeast Wisconsin is a community-based organization whose mission is to serve and support grieving children and their families.

Parent/Guardian Information:

Name: _____
☐ Parent ☐ Guardian
DOB: _____
Participating in the adult sessions?: ☐ Yes ☐ No

Emergency Contact Name/Phone:
_____
_____

Any Medical Conditions or Allergies?: _____
_____
_____

Special Learning Needs?:
_____
_____

Name: _____
☐ Parent ☐ Guardian
DOB: _____
Participating in the adult sessions?: ☐ Yes ☐ No

Emergency Contact Name/Phone: _____
_____

Any Medical Conditions or Allergies?: _____
_____
_____

Special Learning Needs?:
_____
_____

Home Address (Street, City, Zip Code):

_____

_____

Contact Information:

Home/Cell: _____

Work: _____ May Healing Hearts contact you at work? ☐ Yes ☐ No

Email(s): _____

Where/How did you hear about Healing Hearts?

What category best fits your loss or situation that brings you to Healing Hearts?

☐ Death ☐ Divorce ☐ Separation ☐ Abandonment ☐ Incarceration
☐ Immigration/Citizenship Status ☐ Military Deployment ☐ Medical Diagnosis
☐ Other

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Circumstances of Loss (briefly describe what has occurred):

When did this occur? (Date/Year): _____

- **For grant-writing purposes please indicate the following:**

Income Level: ☐ Under $25,000 ☐ $25,000-50,000 ☐ Over $50,000

Ethnic Background: _____

Receive Free/Reduced School Lunch?: ☐ Yes ☐ No

PERSONS AUTHORIZED TO PICK UP CHILD/CHILDREN AT THE END OF WEEKLY MEETING IF YOU ARE NOT IN ATTENDANCE:

Name (First and Last): _____ Phone: _____

Name (First and Last): _____ Phone: _____

CONSENT TO PARTICIPATE IN PROGRAM:

I give my permission for the above-named family members to participate in the Healing Hearts of Southeast Wisconsin program. I understand the importance of my family's attendance at each meeting so that we may get the most benefit from the peer-support program. I am committed to my family's attendance during the 12-week session.

Signature of Parent/Guardian _____ Date:_____

Please return completed form to:

Mail: Healing Hearts
121 Wisconsin Ave.
Waukesha, WI 53186

Email: info.hhwc@gmail.com

Phone: 262-751-0874

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