



2010-11 JUNIOR MEMBERSHIP REGISTRATION FORM 17 YEARS AND UNDER

The information you supply is confidential and will only be used to establish a true portrait of our membership in order to be able to adapt our programs in consequence.

CONTACT INFORMATION

Name s) of junior member's parent/parents: _____

First name: _____ Family name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone: (____) _____ Date of birth: _____

The Junior Member is person with a bleeding disorder (including carriers).

| Type of bleeding disorder | Level of severity | Inhibitors | Infection(s) due to treatment related to your bleeding disorder |
|---|---|---|---|
| <input type="checkbox"/> Factor VII <input type="checkbox"/> Factor IX <input type="checkbox"/> Factor VIII <input type="checkbox"/> Factor XIII <input type="checkbox"/> Von Willebrand <input type="checkbox"/> Carrier <input type="checkbox"/> Other? Which disorder? _____ | <input type="checkbox"/> Severe <input type="checkbox"/> Moderate <input type="checkbox"/> Mild | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> HIV <input type="checkbox"/> Hepatitis C <input type="checkbox"/> Other: _____ |

Treatment

Treatment centre: _____ Treating doctor: _____

Where treating doctor practices (if different from the treatment centre): _____

Type of treatment

Product used: _____ Approximate number of bleeding episodes per month? _____

Has he/she begun prophylaxis? _____ How often? _____ / week

If the Junior member has inhibitors, has he/she started immune tolerance? _____

The Junior member knows someone (people) with (a) bleeding disorder(s).

What is his/her relation to this person (these people)? _____

Please indicate his/her/their name(s)? _____

The junior member is a person who was infected through a blood transfusion.

Date of transfusion: _____ Infection(s) from a blood transfusion: HIV Hepatitis C Other: _____

In which hospital and by which doctor is he/she followed?

HIV: _____

Hepatitis C: _____

Other: _____

The junior member knows someone (people) infected through a blood transfusion.

What is the relation to this person/these people? _____

Please indicate his/their name: _____

The Junior member has lost a loved one.

This person

had a bleeding disorder.

was infected by a blood transfusion.



PLEASE SEND YOUR MEMBERSHIP TO THE FOLLOWING ADDRESS:

Canadian Hemophilia Society - Quebec Chapter
2120 Sherbrooke Street - Suite 1102, Montreal (Quebec) H2K 1C3.

THANK YOU!

