

## Weight Wise Program Registration Form

Name: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Family Physician: \_\_\_\_\_

Current medical concerns (eg. high blood pressure, pre-diabetes, high cholesterol, etc.):

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Current medications:

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Contact Information: Home/Mobile: \_\_\_\_\_

Work: \_\_\_\_\_

Email Address: \_\_\_\_\_

Please check the following:

- I have been given a program information sheet and understand the program start date, meeting time, and meeting place.
- I give consent for the group facilitator (a Registered Dietitian with the Markham Family Health Team) to review my medical record for information pertinent to my care, if applicable.
- I have paid the \$25 registration fee (cash or cheque) and understand that this fee is non-refundable.

Participant signature: \_\_\_\_\_