South Lake Hospital Community Education Childbirth Registration and Payment form

CLASS REGISTRATION

Class(es)	Date(s)	Time(s)	Fee	Location
				NTC
				NTC

	Last Name	First Name	Age	Occupation
Mother				
Father (or Labor Partner)				
Other Labor Partner				

ADDRESS: _____ **City:** _____ **State:** _____ **Zip:** _____
PHONE: Daytime: _____ Cell: _____ E-mail: _____

Doctor/Midwife: _____ Due Date: _____ Hospital: _____
Is this your first pregnancy? Yes _____ No _____
If no, what are the names and ages of other children? _____
Are you planning to Breast _____ Bottle _____ Both _____ feed the baby.

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