

# Leading the WAY to the FUTURE

CINCINNATI, OHIO  
> JUNE 27-30, 2010

## Registration Form

### THREE EASY WAYS TO REGISTER

**Online:** <http://conference.spinabifidaassociation.org>

**Fax:** 518-399-3033

**Mail:** SBA, c/o Site Solutions Worldwide, P.O. Box 215, Burnt Hills, NY, 12027

REGISTRATION OPPORTUNITIES	Early Bird Discount (Register by May 31, 2010)	Regular Fee (Register after May 31, 2010)
<b>Full Conference Attendee or Kids!Camp Registration</b> <ul style="list-style-type: none"> <li>Includes welcoming reception, continental breakfast each day, complimentary lunch on Monday and Tuesday, admittance to all Conference sessions, and exhibit hall pass.</li> <li>Includes welcoming reception, admittance to all Conference sessions, and exhibit hall pass.</li> <li>Optional attendance to Adult Day (for 18+ year olds with Spina Bifida ONLY)</li> <li>Pricing is applicable for first three people in immediate family.</li> </ul>	\$350	\$410
<b>Additional Family Member Registration</b> <ul style="list-style-type: none"> <li>Full Conference registration or Kids!Camp registration for immediate family members in excess of three persons.</li> </ul>	\$300	\$360
<b>Health Care Professional Conference Attendee</b> <ul style="list-style-type: none"> <li>Includes welcoming reception, continental breakfast each day, complimentary lunch on Monday and Tuesday, admittance to all Conference sessions, and exhibit hall pass.</li> <li>Continuing educational credits available.</li> <li>Subscription to Health Care Professional online ListServ.</li> <li>Optional attendance to Clinical Professionals Day (for Health Care Professionals ONLY).</li> </ul>	\$375	\$435
<b>Don't forget to register for these amazing optional social events at the Conference.</b>		
<b>Adult Night</b> (Tuesday) will be confirmed by March 2010 <ul style="list-style-type: none"> <li>For 18+ year olds with Spina Bifida, their partners or professional aides ONLY</li> </ul>	TBD	TBD
<b>Celebration Luncheon</b> (Wednesday)	\$35	\$35
<b>Can't attend the entire Conference? Check out these other registration options.</b>		
<b>One Day Conference Registration</b> <ul style="list-style-type: none"> <li>Can be used for either Monday, Tuesday, or Wednesday sessions.</li> </ul>	\$175	\$235
<b>Adult Day ONLY</b> (Sunday) <ul style="list-style-type: none"> <li>For 18+ year olds with Spina Bifida ONLY.</li> <li>Does not include full Conference registration.</li> </ul>	\$175	\$235
<b>Clinical Professionals Day ONLY</b> (Sunday) <ul style="list-style-type: none"> <li>For Nursing and Health Care Professionals ONLY.</li> <li>Does not include full conference registration.</li> </ul>	\$175	\$235



## CONTACT INFORMATION

Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Organization or SBA Chapter: \_\_\_\_\_

I am a first time attendee to the Conference:  Yes or  No I am a speaker at the Conference:  Yes or  No

I would not like my information shared with Exhibitors:  Yes or  No Transportation to the Conference:  Air  Car  Bus  Train

How did you hear about the Conference?:  Web  Email  Brochure  Advertisement  Article  Previous Attendee  Other

Signature for photo/video consent: \_\_\_\_\_  
*Signing indicates consent for all attendees on the form to be photographed and/or videotaped for promotional and/or educational purposes.*

## REGISTRATION INFORMATION

Attendee Name <i>(please include address if different from above)</i>	Program <i>(please indicate all that apply)</i>	Optional Event: Celebration Luncheon	Does this person have Spina Bifida?	Does this person use an assistive device? <i>(please list)</i>	Does this person have food restric- tions? <i>(please list)</i>	Amount
	<input type="checkbox"/> Adult Full Conference Registration <input type="checkbox"/> Kids!Camp <input type="checkbox"/> Health Care Professional Conference Registration <input type="checkbox"/> One Day Conference Registration <i>(please specify day:_____)</i> <input type="checkbox"/> Adult Day* <input type="checkbox"/> Clinical Professionals Day ONLY*	<input type="checkbox"/> Celebration Luncheon  <input type="checkbox"/> Adult Night <i>(Interested in attending Adult Night? Details will be confirmed by March 2010.)</i>	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ _____ <input type="checkbox"/> No	
	<input type="checkbox"/> Adult Full Conference Registration <input type="checkbox"/> Kids!Camp <input type="checkbox"/> Health Care Professional Conference Registration <input type="checkbox"/> One Day Conference Registration <i>(please specify day:_____)</i> <input type="checkbox"/> Adult Day* <input type="checkbox"/> Clinical Professionals Day ONLY*	<input type="checkbox"/> Celebration Luncheon  <input type="checkbox"/> Adult Night <i>(Interested in attending Adult Night? Details will be confirmed by March 2010.)</i>	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ _____ <input type="checkbox"/> No	
	<input type="checkbox"/> Adult Full Conference Registration <input type="checkbox"/> Kids!Camp <input type="checkbox"/> Health Care Professional Conference Registration <input type="checkbox"/> One Day Conference Registration <i>(please specify day:_____)</i> <input type="checkbox"/> Adult Day* <input type="checkbox"/> Clinical Professionals Day ONLY*	<input type="checkbox"/> Celebration Luncheon  <input type="checkbox"/> Adult Night <i>(Interested in attending Adult Night? Details will be confirmed by March 2010.)</i>	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ _____ <input type="checkbox"/> No	
	<input type="checkbox"/> Adult Full Conference Registration <input type="checkbox"/> Kids!Camp <input type="checkbox"/> Health Care Professional Conference Registration <input type="checkbox"/> One Day Conference Registration <i>(please specify day:_____)</i> <input type="checkbox"/> Adult Day* <input type="checkbox"/> Clinical Professionals Day ONLY*	<input type="checkbox"/> Celebration Luncheon  <input type="checkbox"/> Adult Night <i>(Interested in attending Adult Night? Details will be confirmed by March 2010.)</i>	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ _____ <input type="checkbox"/> No	

## ORDER YOUR 2010 NATIONAL CONFERENCE TEE SHIRT

_____	Adult – Small	(Max. 10)	\$15.00
_____	Adult – Medium	(Max. 10)	\$15.00
_____	Adult – Large	(Max. 10)	\$15.00
_____	Adult – X Large	(Max. 10)	\$15.00
_____	Adult – XX Large	(Max. 10)	\$15.00
_____	Adult – XXX Large	(Max. 10)	\$15.00
_____	Child – Small	(Max. 10)	\$10.00
_____	Child – Medium	(Max. 10)	\$10.00
_____	Child – Large	(Max. 10)	\$10.00

Subtotal \_\_\_\_\_

Add a yearly subscription to SBA's magazine Insights for \$25 \_\_\_\_\_

**TOTAL** \_\_\_\_\_

\*Price is complimentary with full Conference registration. If purchasing without a full Conference registration, please use pricing indicated under other registration options.

## PAYMENT OPTIONS

Check is enclosed. Please make all checks payable to the Spina Bifida Association.

Please charge my credit card:  Visa  MasterCard  American Express  Discover Credit card number: \_\_\_\_\_

Name on card: \_\_\_\_\_ Security code (from back of card): \_\_\_\_\_ Expiration date: \_\_\_\_\_

Address on card (if different from above): \_\_\_\_\_

Signature: \_\_\_\_\_

All or a portion of my fees are being paid by an SBA Chapter or other organization. Please specify organization and amount: \_\_\_\_\_

*Cancellation/refund policy: Cancellation must be received in writing. If received more than 30 days prior to the Conference date, it is subject to a \$25 fee. Cancellation received less than 29 days prior to the Conference date will be subject to a \$50 fee. Cancellation received less than 2 days prior to the Conference date will receive no refund.*

## Kids!Camp Registration

Children of all ages with and without Spina Bifida have a place at our conference. Siblings with and without Spina Bifida are integrated into the Kids!Camp program. There is also a dedicated program for teens without Spina Bifida ages 13-19. Please answer each question completely. If the question does not apply to your child, indicate N/A in the space provided. As in the past, all Kids!Camp Programs will have a maximum capacity in order to ensure quality programming. Please reprint or copy this form for additional children.

CHILD # \_\_\_\_\_ OF \_\_\_\_\_

### INFORMATION

Main Contact Name:		Child's Name:	
Does this child have Spina Bifida? <input type="checkbox"/> Yes or <input type="checkbox"/> No	Sex: <input type="checkbox"/> Male or <input type="checkbox"/> Female	Age:	Date of Birth:
What program are you enrolling your child in?	<input type="checkbox"/> Infant/Toddler 0-2 yrs <input type="checkbox"/> Preschool 3 yrs-Kindergarten <input type="checkbox"/> Youth 1st grade-6th grade <input type="checkbox"/> Teen with Spina Bifida 13-19 yrs <input type="checkbox"/> Brother & Sister without Spina Bifida 13-19 yrs		
Diagnosis in addition to Spina Bifida:			
Level of lesion:	Does your child have a feeding problem? <input type="checkbox"/> Yes or <input type="checkbox"/> No	Is your child verbal? <input type="checkbox"/> Yes or <input type="checkbox"/> No	
Primary method of mobility? <input type="checkbox"/> Manual wheelchair <input type="checkbox"/> Electric wheelchair <input type="checkbox"/> Walks with assistive devices <input type="checkbox"/> Walks unassisted			
Can your child transfer from chair? <input type="checkbox"/> Yes or <input type="checkbox"/> No		Does he/she need help or assistance? <input type="checkbox"/> Yes or <input type="checkbox"/> No	
Does your child have allergies? <input type="checkbox"/> Yes or <input type="checkbox"/> No <i>(If yes, please list)</i>			
Does your child have ADD/ADHD? <input type="checkbox"/> Yes or <input type="checkbox"/> No <i>(If so, please explain behaviors that staff should be aware of)</i>			
Does your child have seizures? <input type="checkbox"/> Yes or <input type="checkbox"/> No <i>(If yes, please explain type, frequency, etc.)</i>			
Napping Time:		Napping Length:	
Bowel/Bladder Information: <i>(Infant/toddler and preschool program only. Youth cathed by age group once in a.m. and p.m.)</i> <input type="checkbox"/> In diapers <input type="checkbox"/> Toilet trained <input type="checkbox"/> Cathed <i>Please describe any specific routines:</i>			

### CONSENT AND RELEASE To be read and signed by parent/guardian. Parent with primary custody must sign.

My child may be picked up from the Children's Program only by the following individuals:

Name:	Relation:	Name:	Relation:
1. I hereby consent for my child to attend and participate in the SBA Annual Kids!Camp Program and other sponsored activities; and			
2. I hereby consent for my child to be photographed/videotaped while attending the Kids!Camp Program and for such photographs/videos to be used for promotional and educational purposes; and			
3. I hereby consent for a licensed RN, LPN, or qualified Nurse's Aide to meet my child's catheterization needs. I will provide supplies needed for catheterization. I also consent to allow the nursing staff and other program staff to contact the community medical emergency services in the case of an emergency and when immediate medical care is necessary for my child in my absence. I will be solely responsible for the cost incurred if an emergency exists; and			
4. I hereby, for myself, my child, my heirs, administrators, personal representatives, executors and assignees, release and discharge the Spina Bifida Association, its employees, agents, volunteers, and contractors, and the Hyatt Regency Cincinnati's property and management from all damages or causes of action, either at law or equity, which I may have or acquire or which may accrue to me, my child, my heirs, administrators, personal representatives, executors, and assignees as result of participation in the Kids!Camp Program including provision of any medical services being provided at the 2010 SBA National Conference.			
Signature of Parent/Guardian: _____		Date: _____	

### ALTERNATE EMERGENCY CONTACT INFORMATION

Name:	Phone:	Cell Phone:
Address:		

Please return form(s) to: SBA Registration

c/o Site Solutions Worldwide, P.O. Box 215, Burnt Hills, NY, 12027

Fax: 518-399-3033

