BeverlyKnightOlson Children's Hospital
NavicentHealth

Family Meal Form

Name of Group: _____

Date/Time of Meal: _____

Contact Person: _____

Phone Number: _____

Email Address: _____

Street Address: _____

Group Leader for meal (*if different than contact person*)**:** _____

Is this your first time bringing meals to the Children's Hospital? _____

***Number of Participants in Group *(max of 7 is allowed)*:** _____

***Are all participants 12 years of age or older?** _____

(Those between 12-17 must be accompanied by an adult; no one under the age of 12 is allowed.)

What food/drink items will you be bringing? *(flyers will be distributed informing the families)*

_____

What will you be bringing the food in? *(individual or large disposable containers recommended)*

_____

Agreement

As a representative of the above named organization, **I have read the Family Meal Guidelines** for the Beverly Knight Olson Children's Hospital, Navicent Health and affirm my groups' willingness to adhere to the Guidelines. I understand that I am not to discuss or disclose any information about any patient outside the hospital or take any photographs or videos during the visit without obtained written consent by the Certified Child Life Specialist or Public Relations Department. I understand that if, during our visit, my group fails to follow these Guidelines, my group may be asked to leave the Children's Hospital and any future visits may be prohibited.

_____ _____

Signature Date

*Please complete this form **prior** to your scheduled visit and email to Whitlock.Erin@NavicentHealth.com. If you have any questions, please contact 478-633-6736.*