

# Registration Form

Coordinated School Health Conference • December 3-5, 2009

Please **ENTER THE NUMBER OF THE SESSION** you want to attend **FOR EACH TIME FRAME**. This information is helpful in making room assignments and avoiding crowding in the sessions. Thank you for your cooperation. **NO PURCHASE ORDERS ACCEPTED!**

**Thursday, December 3, 2009**

Pre-conference Sessions

1:00-4:30 p.m. (Sessions 1-5) \_\_\_\_\_

**Friday, December 4, 2009**

10:15-11:30 a.m. (Sessions 6-11) \_\_\_\_\_

2:00-3:15 p.m. (Sessions 12-17) \_\_\_\_\_

3:30-4:45 p.m. (Sessions 18-23) \_\_\_\_\_

**Saturday, December 5, 2009**

8:30-11:20 a.m. (School Wellness Policies in Action)  Yes  No (Please indicate if attending)

I require a:  vegetarian meal  special meal (please describe) \_\_\_\_\_

I require special arrangements for facilities (please describe) \_\_\_\_\_

**Fees:**

Pre-conference-December 3rd .....\$ 50.00 \$ \_\_\_\_\_

Conference-December 4th-5th:

Early Bird (**before Saturday, November 7th**) .....\$120.00 \$ \_\_\_\_\_

Regular (on or after Saturday, November 7th) .....\$140.00 \$ \_\_\_\_\_

Full Time Student (12 hours with proof of registration) .....\$ 50.00 \$ \_\_\_\_\_

Nursing CEU's .....\$ 25.00 \$ \_\_\_\_\_

Total Enclosed ..... \$ \_\_\_\_\_ **(NO PURCHASE ORDERS ACCEPTED!)**

There have been requests for contact information from past conference attendees. We will be providing a roster of participants to all conference attendees, which includes: Name, Address and Phone Numbers. Please indicate whether you would like your contact information included in the attendee roster. (Only those marked **NO** will be excluded. If this section is **UNMARKED**, that person's information **WILL** be included.)  Yes  No

**PLEASE PRINT LEGIBLY OR TYPE - USE ONLY 1 FORM PER REGISTRANT (This form may be copied.)**

**Please indicate your PRIMARY job responsibility — mark ONE ONLY:**

School Nurse  Health Educator  P. E. Teacher  School Counselor

Administrator  Health Department Employee  Food Nutrition Personnel  Social Worker

Other  \_\_\_\_\_

Name \_\_\_\_\_

Organization \_\_\_\_\_

Organization Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Daytime Phone Number \_\_\_\_\_ Daytime FAX Number \_\_\_\_\_

Email address \_\_\_\_\_

Phone Number to notify you, if conference is cancelled \_\_\_\_\_

Check enclosed. Make check payable to: Missouri Coordinated School Health Coalition (MCSHC). Mail completed registration form and check to: MCSHC, c/o Steiner and Associates, 501 S. Cedar Lake Drive, Columbia, MO 65203.

Credit Card Payment: Please charge my:  Visa  MasterCard  American Express  Discover

Account Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

Signature \_\_\_\_\_

You may register by calling 573-442-2963 or 573-489-0622 or FAX to 573-875-8158 and charging the fee to your Visa, MasterCard, American Express or Discover card. **NO PURCHASE ORDERS WILL BE ACCEPTED!**