



# National Congenital CMV Disease Registry

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## Parent-to-Parent Support Network Consent Form (PDF printer friendly)

Telephone: (832) 824-4387  
Fax: (832) 824-4347  
E-mail: [cmv@bcm.edu](mailto:cmv@bcm.edu)

As an outreach program, the National Congenital CMV Disease Registry maintains the Parent-to-Parent Support Network, a list of families from around the country who have a child with congenital CMV disease and are willing to share their information with other families. To become part of the CMV support network, please complete the following:

I am willing to be part of the CMV support group network. I understand that my name, address, phone number, and any information I provide about my child will be made available to other families of CMV children who need advice and support.

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

My Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Parents' Names: \_\_\_\_\_ Child's Sex: \_\_\_\_\_

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

Home Phone #: (\_\_\_\_\_) \_\_\_\_\_ E-mail address: \_\_\_\_\_

Bilingual Spanish check here  Language other than Spanish or English \_\_\_\_\_

**\* To help us reduce postage fees, Please check one:**  **Send the Support Network list on a diskette**  
 **Email Support Network list**

Please provide a brief description of your child's abilities/disabilities. For example: "At age 3 years, our child is functioning at the 15-month level, has microcephaly, and has some hearing loss, but he is very happy and is just beginning to walk." You may use the back of this printed form, if necessary.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Cochlear implant (check box): Yes  No  If yes, date of implant: \_\_\_\_\_

Please list other resources you have found helpful. For example: magazines/newsletters, toys, support groups, appliances, organizations, etc. (Please use the back, if necessary).

Type of Resource: \_\_\_\_\_  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone #: (\_\_\_\_\_) \_\_\_\_\_ Fax #: (\_\_\_\_\_) \_\_\_\_\_  
Email address: \_\_\_\_\_