



HHID: _____
filled out by WIC Staff

BFPC Enrollment Form

Name: _____

Baby's name (if applicable): _____

Address: _____

Phone: _____ Age: _____

Email: _____

Due Date or Baby's DOB: _____

Sex of baby: Male Female

_____ I am interested in receiving breastfeeding information.

_____ I am currently breastfeeding.

_____ I would like some follow-up support with breastfeeding.

Explanation: _____

Other: _____

I agree to allow the Municipality of Anchorage WIC program to enroll me and share my information with the Municipality of Anchorage Breastfeeding Peer Counseling (BFPC) program. I understand that the Municipality of Anchorage WIC program will protect my personal information and will not share with the Breastfeeding Peer Counseling program any information about me, outside the limits of information needed for BFPC services. I hereby release the Municipality, its officers and employees from any liability relating to any and all communications which include telephone, email, mobile text messaging and social media outlets as a result from my enrollment. I understand that participation in the program is strictly voluntary and I freely chose to participate or end my enrollment at any time and that neither choice will affect my WIC benefits.

Participant Signature

Date

Referral from WIC Anchorage Web Site

Date