



**LOS ANGELES UNIFIED SCHOOL DISTRICT
 HEALTHY START PROGRAM
 Video Presentation Sign-In Form**

School Name: _____ Presentation Date/Time: _____

Comm. Rep. Name: _____

Phone: _____ Fax: _____

Email: _____

	Attendees First and Last Name (Print) <i>Nombre y apellido de los participantes</i> <i>(En Letra de Molde)</i>		Include Phone Number if you would like to be contacted for health insurance assistance. Favor de incluir su número de teléfono si le gustaría ser contactado para asistencia con seguro médico
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When complete, please fax this form to CHAMP at **(213) 241-6888**. Fax must be received before 5:00 p.m. on January 19, 2018.