



Registration Form

Student's Name: \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_

2nd Student's Name: \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_

Mothers Name: \_\_\_\_\_

Fathers Name: \_\_\_\_\_

To be completed by the party who will be financially responsible for the above student

Address \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone :(\_\_\_\_) \_\_\_\_ - \_\_\_\_ Work :(\_\_\_\_) \_\_\_\_ - \_\_\_\_

Other (cell) :(\_\_\_\_) \_\_\_\_ - \_\_\_\_

E-Mail Address: \_\_\_\_\_

Class \_\_\_\_\_ Day/Time \_\_\_\_\_

Class \_\_\_\_\_ Day/Time \_\_\_\_\_

Fill out the information below so we may act quickly in the event of an accident

Who to call if parents cannot be contacted:

Name/Relation: \_\_\_\_\_ Phone:(\_\_\_\_)-\_\_\_\_ - \_\_\_\_

Name/Relation: \_\_\_\_\_ Phone:(\_\_\_\_)-\_\_\_\_ - \_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone:(\_\_\_\_)-\_\_\_\_ - \_\_\_\_

Medical Insurance

CO.: \_\_\_\_\_ Policy# \_\_\_\_\_

Hospital Preference \_\_\_\_\_

Any intolerance to drugs or medication?

Any previous illness or injury the staff should be aware of?

If so, are there any restrictions?

I, the Parent/guardian (circle one) of \_\_\_\_\_, give permission of emergency medical treatment of my child if I cannot first be contacted.

Emergency # not listed above: Phone:(\_\_\_\_)-\_\_\_\_ - \_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Office Use Only
Date of Registration \_\_\_\_\_ Staff \_\_\_\_\_
Payment Type \_\_\_\_\_ Receipt # \_\_\_\_\_