



**REGISTRATION FORM**

Ref #:
Code:

<b>Child's Name</b>				
Last	Middle	First	Date of birth	Sex
<b>Parent's Name(s):</b> Last		First		
Phone: Home	Work	Cell		
Driver's License #:		Email Address:		
Address:			Apt:	
City:	State:	Zip:		
<b>Parent's Name(s):</b> Last		First		
Phone: Home	Work	Cell		
Driver's License #:		Email Address:		
Address:			Apt:	
City:	State:	Zip:		
<b>Emergency Contact Name:</b> Last		First		
Phone: Home	Work	Cell		
Address:			Apt:	
City:	State:	Zip:		
Persons authorized for pick-up:				
<b>Emergency Physician and Dentist Information:</b>				
Physician Name:	Phone#:	Medical plan#		
Address:				
Dentist Name:	Phone#:	Medical plan#		
Address:				
Are your child's immunization up to date? Yes [ ] No [ ]				
Does your child have any special needs, medical concerns, or allergies?				
Does your child have any likes, dislikes or special requests?				
Signature:			Date:	