

FIRST TIME REGISTRATION

Please fill out the following:



Parent/Guardian Name: _____

Spouse's Name: _____

Relationship to child(ren): _____

Address: _____ City: _____ Zip: _____

Email: _____ Contact Phone: _____

1. Child's Name _____ Birth Date: _____ Grade: _____ Gender: _____

Allergies: _____

Medical Conditions or other notes: _____

2. Child's Name _____ Birth Date: _____ Grade: _____ Gender: _____

Allergies: _____

Medical Conditions or other notes: _____

3. Child's Name _____ Birth Date: _____ Grade: _____ Gender: _____

Allergies: _____

Medical Conditions or other notes: _____

4. Child's Name _____ Birth Date: _____ Grade: _____ Gender: _____

Allergies: _____

Medical Conditions or other notes: _____

5. Child's Name _____ Birth Date: _____ Grade: _____ Gender: _____

Allergies: _____

Medical Conditions or other notes: _____