

Registration #: _____
Amount Paid: _____
Check #: _____

C.L.A.S.S.

Registration Form

STUDENT INFORMATION

NAME: _____

ADDRESS: _____

City: _____, State: _____ ZIP: _____

HOME PHONE: (____) - _____

AGE: _____ GRADE LEVEL: _____ SCHOOL: _____

REGISTRATION SESSION: _____

PARENT INFORMATION

Mother's Name: _____

Home Phone: _____ Work Phone: _____

Other: _____

Father's Name: _____

Home Phone: _____ Work Phone: _____

Other: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone: _____

Any additional information I should know about your child:

Medical Concerns:

Asthma ___ Diabetic ___ Seizures ___ Hearing Impaired ___

Other _____

What action should be taken? _____

*****PLEASE MAKE CHECKS PAYABLE TO C.L.A.S.S. (Sorry, credit cards are not accepted)**
Mail this form and payment to: C.L.A.S.S. P.O. Box 56022 Sherman Oaks, CA 91413-1022.