Registration Form

Social Skating for Special Needs

Child's Name: _____
First Last MI

Child's Date of Birth: _____

Home Address: _____

_____
City State Zip

Parent/Guardian Name(s): _____

_____

Home Phone: _(_____)_____-_____

Cell Phone: _(_____)_____-_____

Email Address: _____

Emergency Contact: _____

Emergency Contact Phone: _(_____)_____-_____

Emergency Contact Relationship to Child: _____

Please Select a Session: ___ Session 1
___ Session 2
___ Session 3

_____ I give consent for Theraplayce to take pictures of my child and use them in their publications (ie. website, brochures, patient files, etc…)

Signature:_____ Date: _____