

2010 Spring & Summer Youth Registration Form

908-218-8871 • Youth Enrichment: 908-526-1200, ext. 8404 • Youth Sports: 908-526-1200, ext. 8868 • Fax: 908-526-3576

Check here if this is a new address or telephone number. *Please print clearly.*

Student I.D. Number (if known): _____ Social Security Number: _____ - _____ - _____

Child's First Name: _____ M.I.: _____ Last Name: _____

Check: Female Male Child's Age: _____ Child's Date of Birth: Month: _____ Day: _____ Year: _____

Ethnic: African-American Asian Caucasian Hispanic/Latino Other

Home Address: _____

City: _____ State/Zip: _____ County: _____

Parent Home Phone: (_____) _____ Work Phone: (_____) _____

Cellular Phone: (_____) _____ Home or Business E-mail: _____

● **SPRING PROGRAMS ONLY - PLEASE FILL OUT THE SECTION BELOW**

CRN# (5 digit number)	COURSE TITLE (abbreviate)	START DATE	FEES		CRN# (5 digit number)	COURSE TITLE (abbreviate)	START DATE	FEES	
54321	(example) Sculpture	Apr. 6	\$ 59						
Subtotal:								_____	
Less Discounts Applied:								_____	
Total Fees Paid:								_____	

● **SUMMER PROGRAMS, BEFORE & AFTER CARE, and LUNCH CARE, FILL OUT PROGRAM GRID ON BACK**

● **HEALTH INFORMATION must be completed in full.**

Doctor: _____ Phone: (_____) _____

Current Medications: _____

Mother's Name: _____ Mother's Work #: (_____) _____

Father's Name: _____ Father's Work #: (_____) _____

Emergency Name: _____ Emergency Phone #: (_____) _____

My child's immunizations are up-to-date as required by New Jersey law? Yes No

With this registration I am affirming that my child is in good health with no physical limitations that would hinder (his or her) active participation. Yes No

● **RELEASE INFORMATION for persons not listed above.**

Children will be released to authorized individuals only.

If you wish to have child picked up by someone **not** on this list, you must provide us with a revised list 48 hours before pick-up date.

Name: _____ Relationship: _____

Phone #: (_____) _____

Name: _____ Relationship: _____

Phone #: (_____) _____

RELEASE AUTHORIZATION: If an emergency illness or injury occurs, I hereby authorized Raritan Valley Community College to treat and/or send my child to a physician or hospital and authorize the necessary treatment. I also authorized the physician or hospital to release my child after treatment to a representative of Raritan Valley Community College, if necessary. All information on this form is complete, true and accurate to the best of my knowledge. I give my consent for my child to be photograph or videotaped for promotional purposes. I do not expect compensation when RVCC takes promotional photos and videos of students in the learning environment.

Signature of Parent/Guardian: _____ Date: _____

● **PAYMENT INFORMATION must be completed in full.**

CCCE's POLICY ON REFUNDS: Written withdrawals must be in at least ten (10) business days before the start of the class, less a \$15 or \$25 (Sports Camp) Administrative Fee.

CHECK ENCLOSED - Check #: _____ Make checks payable to: **RVC College** mail to: **RVCC, Corporate & Continuing Education, PO Box 3300, Somerville, NJ 08876**

CREDIT CARD PAYMENT - Check credit card: VISA Discover MasterCard

Name that appears on card: _____

16 Digit Credit Card #: _____ Expiration Date: _____ Cardholder's Signature: _____

● **ALL REGISTRATION INFORMATION must be completed in full in order to ENROLL.**

