Kids & Teens Registration Form

Kids & Teens Programs: 908-526-1200, x8404 ▪ Fax: 908-725-2831

Please print clearly. ❑ New Student ❑ Returning Student ❑ Check here if this is a new address or telephone number

Child's I.D. Number (if known): _____ Child's Social Security Number (optional): _____ - XXX XX _____

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

Check: ❑ Female ❑ Male Child's Date of Birth (required): Month: _____ Day: _____ Year: _____ Child's Age: _____

Ethnic: ❑ African-American ❑ Asian ❑ Caucasian ❑ Hispanic/Latino ❑ Other

Home Address: _____

City: _____ State/Zip: _____ County: _____

Parent Home Phone: (_____)_____ WorkPhone:(_____)_____

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

CRN# (5 digit number)	COURSE TITLE (abreviate)	START DATE	COURSE FEE	CRN# (5 digit number)	COURSE TITLE (abreviate)	START DATE	COURSE FEE
(SAMPLE) 12885	*Puppetry, Writing & Story*	*Sat. Nov 12*	*$95*				

Subtotal: _____

Less Discounts Applied: _____

Total Fees Paid: _____

PLEASE COMPLETE PAYMENT INFORMATION below in order to ENROLL

HEALTH INFORMATION — MUST BE COMPLETED IN FULL

Doctor: _____ Phone: (_____)_____

Current Medications / Allergies: _____

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 (parent/guardian) hereby authorize 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. 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 photographed 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: _____

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

To Register using a credit card, go to **www.raritanval.edu/youth,** *Fax Registrations are not accepted.*

REFUND INFORMATION

KIDS & TEENS PROGRAM'S POLICY ON REFUNDS: Written withdrawals must be in at least ten (10) business days before the start of class, less a $15 Registration Fee.

Revised 091217

All Registration information must be completed in order to enroll.