



## Registration Form

### Student Information

Student's Name \_\_\_\_\_ Nickname \_\_\_\_\_ Please check: F \_\_\_\_\_ M \_\_\_\_\_  
Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Phone \_\_\_\_\_ Email \_\_\_\_\_ Birthdate \_\_\_\_\_

### Parent/Guardian Information

Parent/Guardian Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to student \_\_\_\_\_

Does your child currently receive support services? Please Circle all that apply: OT PT Speech Spec. Ed N/A  
If your child currently receives services through Bright Start, please share your provider's name(s):

Does your child have a medical diagnosis? Please explain: \_\_\_\_\_

Do you feel your child will need extra support to participate fully in our groups? (if yes, please explain on back) \_\_\_\_\_

Name of Persons authorized to pick up student (will need to provide photo identification) \_\_\_\_\_

In case of emergency, and parents/guardians cannot be reached, please contact:

1) Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Are there any medical conditions or allergies we should know about? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, please explain: \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Phone \_\_\_\_\_

Hospital of Choice \_\_\_\_\_ Dentist's Name \_\_\_\_\_ Phone \_\_\_\_\_

**\*\*BSPS policy requires each child enrolled in our programs to be immunized according to New York State Department of Health guidelines. A copy of your child's current immunization record is required to enroll in summer sessions. Any registration form submitted without immunization record is unable to be processed.**

**Payment in full is due at the time of registration. Registration forms submitted without payment are unable to be processed.**

**BSPS reserves the right to cancel sessions with prior notice. In the event a session is cancelled, payment will be refunded.**

**BSPS regrets that we are unable to refund payment for any class/classes that are not attended by the registrant.**

*I agree that in the case of an accident or injury, emergency medical care may be given in the event that I or the person designated cannot be reached.*

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date