CLINIC REGISTRATION FORM

Participant Name ___Male ___Female

Age Date of Birth

Parent Name

Home Address

City State Zip Code

Home Phone

Alternate Phone

E-mail Address

CHOOSE ONE:

❑ Sundays Stroke Development
4:00-5:00 p.m.

❑ Sundays Stroke Refinement
5:00-6:00 p.m.

❑ Fall ❑ Winter ❑ Spring

IMPORTANT INFORMATION (Medical or other)

Make check payable to **Pennsylvania State University.**
777 West Harrisburg Pike, Middletown, PA 17057

Please copy this form for additional registrations.

EMERGENCY MEDICAL TREATMENT FORM will be e-mailed to you and must be completed and returned prior to class.