

# HOPE/LITTLE ANGELS REGISTRATION FORM

NAME \_\_\_\_\_ DOB \_\_\_\_\_ HOME # \_\_\_\_\_

GRADE ENTERING IN SEPT \_\_\_\_\_

PARENT/GUARDIAN \_\_\_\_\_ WORK# \_\_\_\_\_ CELL# \_\_\_\_\_ EMAIL \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

ANY MEDICAL CONDITIONS \_\_\_\_\_

DOCTORS NAME \_\_\_\_\_ PHONE# \_\_\_\_\_

NAME OF MEDICAL INSURANCE \_\_\_\_\_ POLICY # \_\_\_\_\_

CONTACT: NAME \_\_\_\_\_ PHONE# \_\_\_\_\_

I AUTHORIZE THE CLERGY AND ADVISORS TO SEEK MEDICAL ASSISTANCE  
IF NEEDED. I AM WILLING TO ASSIST THE PROGRAM IN THE FOLLOWING  
WAYS: DRIVER \_\_\_\_\_ CHAPERONE \_\_\_\_\_ COACH \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

REGISTRATION FEE: \$35.00 CHECK# \_\_\_\_\_