Turning Tides
A Division of Bridgeway Academy

Turning Tides Community Outreach

Evening Social Skills Program

Registration Form

Date: _____ Preferred Day of the Week: _____

Full Name of Student: _____

Age: _____ Sex: _____ Date of Birth: _____

Parent/Guardian: _____ Parent/Guardian: _____

Occupation: _____ Occupation: _____

Telephone: _____ Telephone: _____

Cell #: _____ Cell #: _____

E-mail: _____ E-mail: _____

Address: _____ Address: _____

City / Province: _____ City / Province: _____

Postal Code: _____ Postal Code: _____

<u>If not available in an emergency notify</u>:

Name: _____ Phone: _____

Address: _____

Name: _____ Phone: _____

Address: _____

****

Family Doctor: _____ Phone: _____

*Medication: _____

If prescribed, please ensure your child has a puffer with him/her at all times.

Allergies: _____

1. Does your child have a psycho-educational assessment? If so, are you willing to share a copy with us?

_____

2. How would you describe your child's self esteem?

_____

3. What are your child's primary hobbies, interest, activities?

_____

4. Please use the space below to provide us with any other information that you feel is important for us to know about your child.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

How did you hear about the program?
_____Website
_____Email
_____Word of Mouth
_____Doctor/Psychologist
_____Fax
_____Other _____