

Community Boating Center

PROGRAM REGISTRATION

PERSONAL INFORMATION

NAME: _____	DATE OF BIRTH: _____	HEIGHT: _____
STREET ADDRESS: _____	SEX: _____	WEIGHT: _____
CITY, STATE, ZIP: _____	EMAIL: _____	
HOME PHONE: _____	HOW DID YOU HEAR OF US? _____	
WORK PHONE: _____		

PROGRAM INFORMATION

PLEASE REGISTER ME FOR THE FOLLOWING PROGRAM(S):

PROGRAM NAME: _____	PROGRAM DATES: _____
PROGRAM FEE: \$ _____	DEPOSIT PAID: \$ _____ BALANCE: \$ _____

EMERGENCY CONTACTS

RELATIVE/FRIEND: _____	DR. NAME: _____
HOME PHONE: _____	DR. PHONE: _____
WORK PHONE: _____	ADDITIONAL _____
CELL PHONE: _____	CONTACTS: _____

FUNCTIONAL ABILITIES

PLEASE INDICATE WHETHER YOU HAVE DIFFICULTY FUNCTIONING FULLY IN ANY OF THE FOLLOWING AREAS:

BOYANCY: Y__ . N__ .	VISION: Y__ . N__ .
CIRCULATION: Y__ . N__ .	HEARING: Y__ . N__ .
MOBILITY: Y__ . N__ .	SENSATION: Y__ . N__ .
DECISION MAKING: Y__ . N__ .	STAMINA: Y__ . N__ .
REASONING: Y__ . N__ .	SPEECH: Y__ . N__ .
MOTOR CONTROL: Y__ . N__ .	BALANCE: Y__ . N__ .

FOR ANY "Y" ANSWERS, PLEASE EXPLAIN YOUR SITUATION: _____

DO YOU HAVE ANY ALLERGIES OR DIETARY RESTRICTIONS? Y__ . N__ . PLEASE SPECIFY: _____

DO YOU TAKE ANY PRESCRIPTION MEDICATIONS? Y__ . N__ .

IF YES, PLEASE SPECIFY NAME OF MEDICATION AND ITS TREATMENT: _____

DO YOU USE ANY ASSISTIVE DEVICES? Y__ . N__ . PLEASE SPECIFY: _____

TERMS AND CONDITIONS:

PARTICIPATION IN OUR CLASSES OR PROGRAMS IS DETERMINED BY THE NUMBER OF SPOTS AVAILABLE AND THE ORDER IN WHICH WE RECEIVE PAYMENT. WE WILL HOLD A SPOT IN THE CLASS YOU HAVE SELECTED FOR UP TO 7 DAYS BY YOUR VERBAL OR EMAIL RESERVATION. YOUR POSITION IN THE CLASS WILL NOT BE GUARANTEED UNTIL WE HAVE RECEIVED PAYMENT. YOUR REGISTRATION PAYMENT IS NON-REFUNDABLE UNLESS WE CAN FIND SOMEONE TO TAKE YOUR PLACE. THANK YOU FOR TAKING A CLASS WITH US!

MAIL COMPLETED FORM AND A CHECK TO THE COMMUNITY BOATING CENTER AT:

PO Box 4272, BELLINGHAM, WA 98227 - 360.714.8891 - INFO@BOATINGCENTER.ORG - WWW.BOATINGCENTER.ORG