TECH CLUB - Introduction to Rocketry

Registration Form Fall Meetings: Oct 23, Nov 6, Nov 20, Dec 4, Dec 11, 2016

Please use a separate form for EACH child registering. Photocopies are acceptable, or download additional forms at www.CatawbaScience.org Return completed form with payment to: Catawba Science Center, PO Box 2431, Hickory, NC, 28603, or fax to (828) 322-1585.

Child's name _____ M__F__ Birthdate (mo./day/yr.) _____/_____/_____

Parent/Guardian _____

Primary phone _____ Is this: □ Home □ Work □ Cell

Secondary phone _____ Is this: □ Home □ Work □ Cell

Address _____ City _____ State _____ Zip _____

E-mail: _____

CSC Member? □ Yes □ No Expires: _____ Membership must remain valid throughout participation in program.

Optional: I give permission for my child(ren)'s name and photographs (still or moving) to be used for promotional purposes of Catawba Science Center. _____ (please initial)

Other individuals allowed to pick up your child(ren):_____

Grade Level: □ 5th □ 6th □ 7th □ 8th

Cost per Quarter: CSC Member: $200; Nonmember: $300

Amount: $_____

Payment Method: □ Check enclosed □ Please call for information □ Charge my: □Visa □ MasterCard □ Discover

Name on Card:_____

Card #:_____ CVV#_____

Expiration Date:_____/_____/_____ Signature:_____

Refund policy: A refund minus an administration fee of $5 will be issued if you cancel at least one week in advance. Cancellations made within one week of the first class will not receive a refund. CSC reserves the right to cancel any programs in the event that minimum class enrollments are not met. If this occurs, your payment will be refunded fully. Individual classes will not be refunded.

Medical Information (Completion Required)

Emergency contact (if parent can't be reached) _____

Phone: Is this: □ Home □ Work □ Cell

Health/Accident Insurance: Employer_____ Ins. Co._____ Policy #_____

Name of insured_____Dr._____Phone_____

Currently on any medications? If so, please list and describe schedule for emergency administration. Include any asthma or allergy medications. If there are medications that must be administered by CSC staff, written directions must be sent.

Allergies_____Medications_____

I,_____, do hereby authorize CSC staff to act on my behalf in seeking any medical treatment or medicine for my son/daughter,_____, during the Tech Club program.

Signature_____ Date_____