ROWAN UNIVERSITY READING CLINIC

CHILD'S NAME _____ **AGE** _____ **GRADE** _____

PARENTS _____ **SCHOOL** _____

ADDRESS _____ **ADDRESS** _____

_____ _____

HOME PHONE ( ) _____ PARENTS DAY/WORK PHONE _____

CELL PHONE ( ) _____ EMAIL ADDRESS _____

Below are the tutoring times. Place a (1) for your first choice and (2) for your second choice. If you do not indicate a second choice, we will assume your child can only come during the time you indicated. Please do not mark a second choice if you know your child cannot attend during that time.

Fall and Spring Clinic:
Every Monday and Wednesday **_____4:00 to 5:00 PM**
_____ 5:10 to 6:10 PM

Summer Clinic:
Monday through Thursday **_____ 8:55-10:10**
_____ 10:20-11:35

If you have plans that may cause your child to miss any sessions of clinic, please note the dates here:

_____

Rowan University Reading Clinic is a teaching and research facility. By enrolling my child in the clinic you understand that information from clinic files and tutoring sessions may be used for research purposes. Anonymity is assured.

_____ _____
(Date) **(Parent's Signature)**

PLEASE RETURN THIS FORM WITH A CHECK IN THE AMOUNT OF $325.00

Mail to: ROWAN UNIVERSITY,
James Hall, LLSE – Reading Clinic
201 Mullica Hill Road
Glassboro, New Jersey 08028