ROWAN UNIVERSITY READING CLINIC

Registration Form

CHILD'S NAME_____ AGE _____ CURRENT 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 CLINIC	**Monday and Wednesday**	**_____4:00 to 5:00 p.m. *or***
		_____5:10 to 6:10 p.m.
SPRING CLINIC	**Monday and Wednesday**	**_____4:00 to 5:00 p.m. *or***
		_____5:10 to 6:10 p.m.
SUMMER CLINIC	**Monday through Thursday**	**_____8:55 to 10:10 a.m. *or***
		_____10:20 to 11:35 a.m.

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

_____

Has your child ever attend our clinic? _____ If so, when? _____

Rowan University Reading Clinic is a teaching and research facility. By enrolling my child in the clinic, I 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 SHEET WITH A CHECK IN THE AMOUNT OF $325.00 Mail to:

ROWAN UNIVERSITY, Reading Department- College of Education 1st floor

201 Mullica Hill Road

Glassboro, New Jersey 08028