

ST. JOSEPH'S SCHOOL FOR THE DEAF

American Sign Language Program

Registration Form – FALL 2019

Name: _____

Address: _____

City/State: _____ Zip code: _____

Home phone number: _____ Cell phone number: _____

Email address: _____

*If possible, please put me in the same class with:

Name of friend/family member

Name of child attending SJSD (if applicable): _____

Name of child's teacher: _____

Please **check** your class level below:

____ Beginner I ____ Beginner II ____ Intermediate I/II ____ Advanced I

____ First time applicant ____ Returning applicant ____ Receipt needed

**** REMINDER...payment is NON-REFUNDABLE ****

(DO NOT WRITE BELOW THIS LINE)

Registering as a:

____ **SJSD Family Member** ____ **Community Member** ____ **Student**

____ **Senior Citizen** ____ **Staff**

Received by: _____ **Amount received: \$** _____

Date: ____ / ____ / ____ **Instructor:** _____