ST. JOSEPH'S SCHOOL FOR THE DEAF

American Sign Language Program

Registration Form

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:** ______________________________