

Teaching Classes Registration 2009/ 2010

	First name	Surname	Date of Birth
1st Child	<input type="text"/>	<input type="text"/>	<input type="text"/>
2nd Child	<input type="text"/>	<input type="text"/>	<input type="text"/>
3rd Child	<input type="text"/>	<input type="text"/>	<input type="text"/>
4th Child	<input type="text"/>	<input type="text"/>	<input type="text"/>

Address

Parent Contact Details

Parent Name

Phone

Email

Please tick required Training Day and Time

Tuesday	3:30 – 4:15	<input type="checkbox"/>
	4:15 – 5:00	<input type="checkbox"/>
Friday	3:30 – 4:15	<input type="checkbox"/>
Saturday	10:15 – 11:00	<input type="checkbox"/>
	11:00 – 11:45	<input type="checkbox"/>
	11:45 – 12:30	<input type="checkbox"/>

Parent's Signature