Family Support Center
Registration Form
Please complete the following form.

Name _____

Nickname_____

Address_____

City_____ Zip Code: _____

Phone ( ) _____

Parent's E-mail Address: _____

Parent/Guardian with legal custody to be contacted in case of illness or injury:

Name: _____
Home Phone #: _____
Relationship to Individual: _____
Cell Phone # _____
Email _____
Work Phone # _____

Individual Name:
Medical Insurance Information
The individuals is covered by family medical/hospital insurance [ ] Yes [ ] No
Include a copy of your insurance card; copy both sides of the card so information is readable.
Insurance Company _____
Policy # _____
Subscriber_____
Insurance Company Phone # _____

Health Care Providers:

Name of Individual's primary doctor(s): _____

Address: _____

Phone: _____