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July "Power Packed Vocab" Camp 2018 /Registration

_____	M/W/F Class	_____	T/TH Class
Name:	_____	Date of Birth:	_____
Address:	_____	Home #:	_____
	_____	Cell:	_____
Email:	_____	Work:	_____
Emergency:	_____	Phone:	_____
Contact			
Food Allergies	_____		
Other Allergeries:	_____		
Hospital Pref	_____		
Pediatrician:	_____		
Name of Practice:	_____	Phone:	_____

By signing below, I acknowledge that all the information above is accurate and correct and will inform Capitol City Speech Therapy if any information changes. I agree to pay the non refundable registration fee when this form is submitted. Fee will hold your child's spot and will not go towards tuition (it will help pay for supplies)

Registration fee is \$25.00

_____/_____/_____
Legal Guardian Signature: _____ Date