Phonics Clinic

APPLICANT/STUDENT ADMISSION FORM

Applicant/Student 1 Contact Information:

First Name: Last Name: Preferred Name:

Email: Birthday:

Primary Phone Type: Cell ☐ Home ☐ Primary Phone Number:

Applicant/Student 2 Contact Information:

First Name: Last Name: Preferred Name:

Email: Birthday:

Primary Phone Type: Cell ☐ Home ☐ Primary Phone Number:

Applicant/Student 3 Contact Information:

First Name: Last Name: Preferred Name:

Email: Birthday:

Primary Phone Type: Cell ☐ Home ☐ Primary Phone Number:

Address Information (Optional):

Street Address: City: State: Zip Code:

Parent/Guardian Contact Information:

Name Prefix: First Name: Last Name:

Primary Phone Type: Cell ☐ Home ☐ Primary Phone Number:

Email:

Address Information (If different from above):

Street Address: City: State: Zip Code:

Relationship Information:

Parent ☐ Guardian ☐

Other Information:

How did you hear about us:

Questions / Comments / Concerns: 1(617)-331-2721

Rev. 1.0 Date: 11/01/22

Phonics Clinic

Which Group do you wish to Join:

☐	Group 1	Monday & Wednesday	5:30-7:30 pm
☐	Group 2	Tuesday & Thursday	5:30-7:30 pm

Parent/Guardian Signature:

By signing below, you agree that the above information is true and accurate.

_____ _____ _____

Print Name *Signature* *Date*

Student Signature:

By signing below, you agree that the above information is true and accurate.

_____ _____ _____

Print Name *Signature* *Date*

****NOTE** Please send completed forms to: jnichols@PhonicsClinic.com**

Questions / Comments / Concerns: 1(617)-331-2721

Rev. 1.0 Date: 11/01/22