

RRISD COMMUNITY EDUCATION REGISTRATION FORM

MAIL TO:

RRISD Community Education Office
 12515 Mellow Meadow Drive
 Austin, TX 78750
 FAX: (512) 464-4091 TEL: (512) 464-4112

www.roundrockisd.org/communityed

DO NOT SEND FORM BACK TO YOUR CHILD'S SCHOOL!

OFFICE USE

Date: _____ Amt: \$ _____

Type: _____ By: _____

Participant's Name _____
Last First M.I.

Address _____
Street City Zip

Home Phone _____ Work Phone _____ Email _____

COURSE #	COURSE TITLE	DATES	DAYS	TIME	LOCATION	FEE

MAKE CHECKS PAYABLE TO: ROUND ROCK ISD (RRISD) DO NOT SEND FORM BACK TO YOUR CHILD'S SCHOOL NO confirmation or reminder cards/calls will be given. Please call Community Education office to confirm.	TOTAL FEE	
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CHECK ENCLOSED - Driver's License # _____ State _____

CREDIT CARD # _____ Last 3 digits from the back of credit card _____ EXP. DATE _____

Name Exactly as it appears on card: _____ Signature: _____

REFUND POLICY: Refunds will be made only if there is insufficient enrollment in a particular class. Other refunds will not be made due to the low course charges and the expense of programming. Refunds may take at least four weeks to process. A credit memo of 75% of the class fee will be given for a future class if a student withdraws at least one week before the class. No credit will be given if student withdraws two-business days prior to the start of the class or less. Requests must be made in writing, either by mail or fax. Credit memo may take up to 4 weeks.

WAIVER OF CLAIMS: "I hereby waive any claim I might have against the Round Rock Independent School District or any of its agents, which might arise from any injury or other damage I might incur while on the property of Round Rock Independent School District or while participating in any activity sponsored by the Round Rock Independent School District. I have read and acknowledge the refund policy."

Date _____ Signature _____

EMERGENCY INFORMATION FORM

(Must be sent in for children ages 18 and younger only)

Medical Conditions: _____

Name of Student _____ GRADE LEVEL as of April 1, 2010 _____ Age _____

Mother's Name _____ Business Phone/Cell Phone _____

Father's Name _____ Business Phone/Cell Phone _____

If your child should become ill or accidentally injured during a Community Education class and the Community Education office is unable to reach a family member, the office will call the person(s) you name below:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

If a friend or family member cannot be reached, the Community Education office will contact the physician you indicate below:

Physician's Name _____ Office Phone _____

ASSURANCE: If the Community Education office is unable to reach a family member, friend, or the physician indicated above and my child is in need of emergency medical treatment, I hereby authorize the Community Education staff to obtain emergency medical treatment and the emergency physician to administer medical treatment to my child. I have read Registration / Refund information.

Signature of Parent or Guardian _____

Date _____