

Clarksville Intramural Program

Student's Name: _____

Grade: _____

Parent/Guardian Name(s) and Contact Information: _____

Primary Contact: _____

Phone: _____ Email: _____

Secondary Contact: _____

Health Concerns (allergies, medications, etc): _____

Phone: _____ Email: _____

I prefer to receive: _____ phone calls _____ emails

VERY IMPORTANT:

Please provide phone numbers that we can use to contact you during program hours from 3:15 -4:15pm. Transportation is not provided and students will need to be picked up promptly at 4:15.

____ Yes, my child has permission to participate in the Clarksville Intramural Program and I have explained the behavioral and attendance expectations to my child. **I will pick up my child/arrange for my child to be picked up at 4:15.**

____ No, my child does not have permission to participate in the Clarksville Intramural Program.

Parent Signature

Date

****Please return to Mrs. Taylor!****