Clarksville Middle School Intramural Program

Intramural Program: ____________________________________________

Program Description: __________________________________________

________________________________________________________________

Program Time: _________________________________________________

Sponsor: ___________________________ Email: _____________________

________________________________________________________________

Student's Name: _______________________________________________

Parent/Guardian Name(s): _______________________________________

Phone: ___________________________ Email: _____________________

Secondary Contact: ____________________________________________

Phone: ___________________________ Email: _____________________

Health Concerns/Allergies: ______________________________________

Preferred Method of Contact: _________ Phone  _________ Email

________________________________________________________________

VERY IMPORTANT:

Please provide phone numbers that we can use to contact during program hours from 3:15-4:15pm.

Transportation is not provided and students will need to be picked up promptly at 4:15pm.

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

Parent/Guardian Signature: ______________________________________

Date: __________________________