

REGISTRATION FORM

DOWN SYNDROME READING CLINIC

LOCATION:

Down Syndrome Association of Houston Resource Center
 7015 W. Tidwell, Bldg G, Suite 108
 Houston, Texas 77092

PARTICIPANT INFORMATION:

Parent Name:					
Parent Address:					
Parent Telephone:					
Parent Email Address:					
Child's Name:					
Child's Age:					
Date of Session: (Please circle the preferred date)	Mon. Jan. 23	Tue. Jan. 24	Wed. Jan. 25	Thu. Jan. 26	Fri. Jan. 27
Time Preference: (Please circle the preferred time)	AM: 8	9	10	11	
	PM: 1	2	3	4	5
Note: Dates & times are given out on a "First Come/First Serve" basis.					
Please use this space to tell me more about your child:					

Please complete the information above and mail this registration form, together with your payment of \$100, to:
 Joanne Mothes
 257 Old Spring Lane
 Dublin, Ohio 43017
 Tel: 614-799-8921 (evenings)