



905 727 7144 phone

905 727 3244 fax

info@watsonsfamilykarate.com

CONTRACT 2017 – 2018 SCHOOL YEAR

FAMILY NAME: _____

EMAIL ADDRESS _____

GIVEN NAME: _____ AGE: _____ D.O.B. _____

GIVEN NAME: _____ AGE: _____ D.O.B. _____

GIVEN NAME: _____ AGE: _____ D.O.B. _____

GIVEN NAME: _____ AGE: _____ D.O.B. _____

HOME ADDRESS _____

_____ PHONE: _____

SCHOOL ATTENDING: _____

SCHOOL ADDRESS: _____

SCHOOL PHONE: _____ SCHOOL DISSMISSAL TIME _____

START DATE OF SERVICE: _____

WHICH DAYS ARE REQUIRED: FULL _____ MON _____ TUES _____ WED _____ THUR _____ FRI _____

DROP OFF IS AT WATSON'S FAMILY KARATE SCHOOL
40 ENGELHARD DR. UNIT 9
AURORA, ON L4G 6X6

MOTHER/GUARDIAN
WORK PHONE _____ CELL PHONE _____

FATHER/GUARDIAN
WORK PHONE _____ CELL PHONE _____

EMERGENCY INFORMATION;

CONTACT PERSON: _____

RELATIONSHIP TO CHILD; _____

PHONE NUMBER _____

Does your child require a booster seat Yes___ No___

Does your child have any life threatening allergies or Medical conditions which we should be aware of?

Do we have your permission to call 911 in case of a medical emergency or vehicle accident?

Yes___ No ___ Sign: _____

Any other significant information we need to know?
