



CAPITOL ROOTS STUDIO & PRODUCTIONS
REGISTRATION FORM

I. RETURNING STUDENT CONTACT INFORMATION

DATE: _____

LAST NAME	FIRST NAME
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II. NEW STUDENT CONTACT INFORMATION

DATE: _____

LAST NAME	FIRST NAME
PARENT / GUARDIAN NAME:	
PARENT / GUARDIAN NAME:	
STREET ADDRESS	
APT/UNIT #	
CITY	STATE / ZIP
HOME PHONE () -	PARENT / GUARDIAN CELL:
	PARENT / GUARDIAN CELL:
STUDENT BIRTHDAY	AGE
STUDENT EMAIL	
PARENT EMAIL	

III. CLASS INFORMATION

OPTION 1: UNLIMITED CLASS OPTION:	Please check one	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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OPTION 2: SELECTED CLASS OPTION (Up to 4 classes/week)			
PLEASE LIST ALL CLASS INFORMATION YOU ARE INTERESTED IN TAKING			
1. Class Name		Days & Times	
2. Class Name		Days & Times	
3. Class Name		Days & Times	
4. Class Name		Days & Times	

OPTION 3: CLASS CARD OPTION:	Please check one		
<input type="checkbox"/>	6 CLASSES/MO	Initial Date:	
<input type="checkbox"/>	10 CLASSES/MO	Initial Date:	

OPTION 4: DROP-IN CLASS OPTION:			
PLEASE LIST THE CLASS INFORMATION YOU ARE INTERESTED IN TAKING			
Class Name		Day & Time	