



**SPACES ARE LIMITED SO PLEASE REGISTER EARLY  
REGISTRATION FORM**

Child's name: \_\_\_\_\_

Age: \_\_\_\_\_ DOB (MM/DD/YYYY) \_\_\_\_\_ Sex M \_\_\_\_\_ F \_\_\_\_\_

School name/District: \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

Preferred contact method (circle) : Home Cell Email Other \_\_\_\_\_

| General Questions<br>(to help us tailor our program for your child)                        | If Yes, please explain. |
|--|-------------------------|
| Does your child have any visual difficulties or eye defects?                               |                         |
| Does your child have any auditory impairments?   |                         |
| Are there any health problems we should know about?  |                         |
| Is you child in any special placements in school (reading, match, speech, OT, or Title 1)? |                         |
| Is there anything else we should know about your child?                                    |                         |

How did you hear about us? \_\_\_\_\_

I authorize my child to receive instruction from Mind Lab Massachusetts.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please make checks payable to Mind Lab Massachusetts  
180 Wells Avenue, Newton, MA 02459 – Questions call 617.527.1507**