

STRATFORD PUBLIC SCHOOLS CONTINUING EDUCATION REGISTRATION FORM

DATE

(Please Print)

COURSE TITLE	COURSE #	START DAY	DAY	TIME	LOCATION	ROOM	FEE

STUDENT NAME _____
LAST FIRST MIDDLE INITIAL

ADDRESS _____ CITY _____ ZIP CODE _____

E-MAIL ADDRESS _____

HOME # _____ WORK # _____

CIRCLE LAST GRADE ATTENDED: 1 2 3 4 5 6 7 8 9 10 11 12
 (Optional) COLLEGE 1 2 3 4 5 6 7 8

OCCUPATION (Optional) _____ DATE OF BIRTH/AGE (Senior Only) _____

Make checks payable to **STRATFORD CONTINUING EDUCATION • 45 North Parade • Stratford, CT 06615**

OFFICE USE ONLY	CASH	CK. NO.	AMOUNT	TOTAL	BALANCE

SPECIAL NOTES: _____ ACCEPTED: _____