The Chick Rosnick Boxing Club Inc.
360 Sniffens Lane
Stratford, CT 06615
203-551-4691
Registration Form

Welcome to the Chick Rosnick Boxing Club Family! Please fill out the form completely.

Date_____

Part One - Participant Information

Name (First): _____ (Last): _____ Middle): _____

Preferred Pronoun: _____

Date of Birth: _____ Age: _____

Race:
Asian ____ Black ____ Hispanic ___ Native American ___ White ____ 2 or More Races _____

Gender: Male ____ Female ____ Nonbinary____

Address:_____

City: _____ Sate: _____ Zip: _____

Phone (Cell): _____ (Home): _____

Email: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone: _____

Emergency Contact Email: _____

Part Two - Participant Medical Information

I hereby grant permission for a member of The Chick Rosnick Boxing Club to contact the following medical professional to obtain emergency medical care if warranted

Physician: _____ Physician Phone: _____

Physician Address: _____

Preferred Hospital: _____

Please list all allergies, medical needs, dietary needs or any other areas of concern:

_____

_____

_____

_____

_____

_____

_____

********Please fill out the information below if participant is under 18 years old********

Family Information

Parent/Guardian Name:_____

Parent/Guardian Address:_____

Parent/Guardian Phone:_____

Parent/Guardian Email:_____

Parent/Guardian Occupation:_____

Parent/Guardian Drivers License:_____

Are you currently Involved with DCF? **Yes:_____ No:_____**

If yes, DCF Social Worker Name:_____

Were you previously Involved with DCF? **Yes:_____ No:_____**

Date case closed: _____ Additional Comments: _____

Participant Program Data

School Name: _____

School Address: _____

Grade: _____ GPA: _____ Projected Start Date: _____

Height: _____ Weight: _____ Shoe Size: _____ Waist: _____

Parent/Guardian Signature: _____ Date: _____