

ACA Course Registration

Your registration form will only be viewed by the ACA Facilitator and is used for general participant information and certificate purposes only.

PARTICIPANT INFORMATION

First Name

Last Name

M.I.

Street address

Street address line 2

City

State

Zip code

Gender Identity

Birth Date

Phone number

Female

Male

E-mail address

Place of work

Have you attended this course before?

Yes

No

Course you are interested in attending:

SUNDAY 2-4pm

TUESDAY 6-8pm

UNSURE

Reason for taking this course (check all that apply):

Required for DFPS

Required for Probation

Current ECCC Client

General Education

Improve Professional Knowledge

Class/Course/Certification Credit

Other

I authorize the ACA Facilitator to release the following information:

I have registered for the ACA Course

My ACA Course attendance record

If I stop attending or am dropped from the ACA Course

My ACA Course Completion

Any and all information relating to my attendance, participation, or status in the ACA Course

None- unless it is a mandated report as defined by Texas Family Code Section 261.101

INFORMATION RELEASE:

If applicable, the information above may be released to:

Agency:

Primary phone number

E-mail Address

In case of an medical emergency, please contact:

First name

Last name

Phone Number

Relationship to Participant

Participant Signature

Date

Please list any of the following: Current medications, medication allergies, food allergies, or chronic health concerns.

Please share anything else you'd like for us to know about you:

Participant Signature

Date:

**OFFICE USE
ONLY:**

RECEIVED BY:

DATE: