



FRAMBOYANT
learning center
Where The Future Begins

REGISTRATION FORM

DATE: _____

Mother's name _____ Probable due date _____

Surnames _____ Age _____

Father's name _____ Surnames _____ Age _____

Mother occupation _____ Father's Occupation: _____

Address _____ ZIP _____ Phone _____

E-mail _____ Address _____

ZIP _____ Hospital _____ Number of pregnancies _____ Births _____

Abortions _____ Doctor _____ Phone _____

Address _____ Zip _____

Did the Doctor recommend? YES () NO ()

Who recommended? _____

Complications during pregnancy? _____

Previous pregnancy or childbirth complications _____

Objectives that you intend to take this course _____

State of health: Optimum () Good () Other ()

Please specify if you have any problems with:

Digestive system _____

Musculoskeletal system _____

Cardiovascular system _____

Nervous system _____

Are you currently exercising? YES () NO ()

What type of exercise? _____

- 12 classes lasting two hours, one class per week
- Cost of the course \$540
- Cash 10% discount, \$486
- 2 payments of \$270 at the beginning of the course, second payment a month after starting the course

CLASS ATTENDANCE 1. ____ 2. ____ 3. ____ 4. ____ 5. ____ 6. ____ 7. ____ 8. ____ 9. ____ 10. ____
11. ____ 12. ____

Date of expulsion _____

Additional Classes YES () NO ()

Date additional classes 1. ____ 2. ____ 3. ____ 4. ____ 5. ____

PAYMENT FEES:

Total: _____ Date: _____ Received _____

Please write down date on which payments will be made with no more than 15 days difference between each payment.

1st. Date _____ Amount \$ _____ Received _____

2nd Date _____ Amount \$ _____ Received _____