

FAMILY REGISTRATION FORM

**22<sup>ND</sup> ANNUAL FAMILY/TEACHER CONFERENCE FOR DEAF-BLIND (JUNE 19-23, 2009)  
EMBASSY SUITES, GREENSBORO**

**SPONSORED BY: THE NORTH CAROLINA DEPARTMENT OF PUBLIC INSTRUCTION**

<b>RETURN APPLICATION TO:</b>	CHRIS JONES N.C. DEPARTMENT OF PUBLIC INSTRUCTION EXCEPTIONAL CHILDREN DIVISION 6356 MAIL SERVICE CENTER RALEIGH, NC 27699-6356
FAX: 919-807-3243	

PLEASE PRINT OR TYPE

I **WILL** bring a child care provider                       I **WILL NOT** bring a child care provider

**REGISTRATION AND DEPOSIT (\$50 MADE PAYABLE TO DBMANC) MUST BE RETURNED BY MAY 12, 2009**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: (DAY) \_\_\_\_\_ (EVENING) \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

EMAIL: \_\_\_\_\_ (CRITICAL-MUST BE CORRECT)

NAMES OF ALL ADULTS ATTENDING AND RELATIONSHIP TO YOUR CHILD WITH DEAF-BLINDNESS:  
*(WE CAN ONLY ALLOW ONE HOTEL UNIT PER FAMILY)*

NAME	RELATIONSHIP

DO YOU NEED A SIGN LANGUAGE INTERPRETER FOR THE MEETINGS?    YES \_\_\_ NO \_\_\_

DO YOU REQUIRE ANY OTHER SPECIAL CONSIDERATIONS? SPECIFY: \_\_\_\_\_

CHILD(REN) ATTENDING: **(No child older than 14 can attend unless it is your child who is deaf-blind or a care provider)**

NAME	AGE	DISABILITIES	KNOW HOW TO SWIM

SIGNATURE: \_\_\_\_\_

OUR CHILD CARE PROVIDER IS:

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

DO ANY ADULTS/CHILDREN IN YOUR FAMILY REQUIRE A HANDICAPPED ACCESSIBLE HOTEL UNIT?

If yes, Name: \_\_\_\_\_

**APPLY EARLY - LIMITED SPACE AVAILABLE**