



Infant Massage Classes

Registration Form

Parent Name: _____

Infant's Name: _____

Infant's Age: _____

Address _____

Phone _____

Email _____

Will you be able to attend all 5 sessions? Yes No

Classes: 04/10, 04/17, 04/24, 05/01, 05/08 all sessions begin at 6:30 pm to 7:30 pm

FAX or EMAIL FORM TO:

Office of Special Needs

CRYSTAL KEWANIMPTewa

EMAIL: CKewanimptewa@hopi.nsn.us

PHONE:(928) 734.3418

FAX (928) 734-2529

OFFICE USE ONLY:

Date Received: _____

Staff Int. _____