



**SKYVIEW MIDDLE SCHOOL
2009-2010 ATHLETICS**

Athlete's Name: _____

Grade: _____ Sport: _____

Parent/Guardian Name: _____

Address: _____

City: _____ Zip code: _____

Home Phone: _____ - _____ - _____

Work Phone: _____ - _____ - _____

Cell Phone: _____ - _____ - _____

Physical: _____ Attached
_____ On File at Skyview Health Office
(good for 3 years)

Fee Payment (Please see fee schedule):
_____ check _____ cash
(Checks made payable to Skyview Athletics)

Payment must accompany registration. Bring or mail
this form with payment to:

**Susan Akervik, Athletic Director
Skyview Middle School
1100 Heron Avenue North
Oakdale, MN 55128**