DANCE CONCEPTS

DANCER'S NAME: _____

DATE OF BIRTH: _____ AGE: _____

SCHOOL: _____ GRADE: _____

STREET ADDRESS: _____

CITY, STATE, ZIP _____

EMAIL: _____

PARENT/GUARDIAN NAME: _____

TELEPHONE (CELL): _____ (HOME): _____

DO YOU HAVE ANY MEDICAL PROBLEMS WE SHOULD BE AWARE OF?

_____

DO YOU HAVE ANY ALLERGIES? _____

IF YES (TO MEDICAL/ALLERGIES), PLEASE EXPLAIN: _____

_____

EMERGENCY CONTACT NAME: _____

RELATIONSHIP: _____ PHONE: _____

I HEREBY RELEASE DANCE CONCEPTS, EMPLOYEES/INDEPENDENT CONTRACTORS FROM ALL LIABILITY FOR PERSONAL INJURY, ILLNESS OR PROPERTY DAMAGE OCCURRING ON OR OFF THE STUDIO'S PREMISES.
I HAVE READ DANCE CONCEPTS GENERAL INFORMATION AND STUDIO POLICIES AS OUTLINED.
I AUTHORIZE DANCE CONCEPTS TO SEEK MEDICAL TREATMENT AT THE NEAREST MEDICAL FACILITY AND THEY MAY CALL PARAMEDICS AND DISCHARGE ME/MY STUDENT TO AN AMBULANCE IF I AM NOT ABLE TO AUTHORIZE IT IN THE CASE OF A MEDICAL EMERGENCY.
I CERTIFY THAT MY CHILD IS IN GOOD HEALTH AND CAPABLE OF PARTICIPATING IN PHYSICAL ACTIVITIES.
I HEREBY GIVE PERMISSION TO DANCE CONCEPTS TO TAKE AND USE PHOTOGRAPHS FOR PROMOTIONAL USES FOR THE STUDIO.
I UNDERSTAND THAT PAYMENT IS NOT REFUNDABLE AND DUE EVERY MONTH.

_____ _____

PARENT NAME (PLEASE PRINT) PARENT SIGNATURE DATE

_____

CLASS: _____ DAY: _____ TIME: _____ TUITION: _____

CLASS: _____ DAY: _____ TIME: _____ TUITION: _____