___ New Student ___ Current Student ___ Returning Student

Alice DePass Studio of Dance, Inc.

Student Registration Form: Summer 2017

STUDENT INFORMATION

Student's Name: _____ Birth Date: _____ Age: _____

School: _____ Grade: _____

Home Address: _____ City: _____

Zip Code: _____ Home Phone Number: _____

PARENT(S)/GUARDIAN(S) RESIDING WITH CHILD

1. Name: _____ Relationship to Child: _____

Cell Phone: (_____)_____ Work Phone: (_____)_____

E-Mail: _____ Place of Employment: _____

2. Name: _____ Relationship to Child: _____

Cell Phone: (_____)_____ Work Phone: (_____)_____

E-Mail: _____ Place of Employment: _____

SEPARATED PARENT

Name: _____ Relationship to Child: _____

Authorized to Pick Up Child: Yes_____ No_____

Home Address: _____ City: _____ State: ____ Zip: _____

Contact Phone: (_____)_____ E-Mail Address: _____

ALL PERSONS AUTHORIZED TO PICK UP CHILD

1. Name: _____ Relationship to Child: _____ Phone: _____

2. Name: _____ Relationship to Child: _____ Phone: _____

3. Name: _____ Relationship to Child: _____ Phone: _____

CLASS/CAMP PARTICIPATION

Class/Camp Name	**Day(s)**	**Time**
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

How did you hear about our studio? _____

Previous Dance Training
Please list prior dance experience (i.e. number of years, technique studied, teachers, etc.):

_____

Does your dancer have any food allergies? _____

PAYMENT INFORMATION

Class tuition:_____ Camp tuition:_____ Total:_____ (*cash or check only*)

I understand that one make-up class is permitted for each class my child misses. Make-up classes must be taken within 30 days of the missed class(es). I also understand that all fees paid are ***nonrefundable and nontransferable*** *(if you have any questions, please see the front desk). The NSF fee for returned checks is $35. Should this provision have to be enforced by legal means, the undersigned person(s) is responsible for payment, as liquidated damages, the costs of collection, plus interest at the legal rate and reasonable attorney's fees as determined by the Court or 15% of the amount collected failing such determination.*

PERSON RESPONSIBLE FOR PAYMENT:

PRINT NAME: _____ SIGNATURE: _____

DATE: _____ RELATIONSHIP TO STUDENT: _____

WITNESS *(Must be at least 18 years of age)*: _____

RELEASE AND AUTHORIZATION

Name of Student: _____

Indicated in the space below are any health problems or conditions of which the studio should be aware (such as heart, back, medical, allergy, muscular, pregnancy, diabetes, epilepsy, chemical or neurological condition, special medication, knee/kidney/shoulder problems, etc.). I understand that risk of *injury* is inherent in any physical activity and I, on behalf of myself and my child, knowingly and voluntarily accept that risk. I, the undersigned, for myself, my heirs, administrators, and executors, herby waive and release Alice DePass individually and Alice DePass Studio of Dance, Inc., its staff, and Encore Dance Theatre, Inc. from any and all claims or damages of any kind arising out of my child's participation in the exercise and/or dance program of Alice DePass Studio of Dance, Inc. I further certify that the aforementioned student is in proper physical condition to participate in the exercise/dance program and that he/she has been examined by a licensed physician and found to be in proper physical condition to participate in said program. I, the undersigned, do herby authorize Alice DePass or her designated agents (being teachers or administrators employed by Alice DePass Studio of Dance, Inc.) to obtain medical treatment for my said child in emergency situations where I cannot be reached in time to authorize the treating physician to provide such emergency medical services. I understand that I am responsible for any medical expenses and that the absence of health insurance does not make Alice DePass Studio of Dance, Inc. responsible for payment of medical expenses. This authority includes the power to authorize any and all treatment deemed necessary under the circumstances by a licensed physician. This power is in essence a power of attorney and shall remain in effect for one year from the date signed below.

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____

WITNESS *(Must be at least 18 years of age)*: _____

EMERGENCY INFORMATION

Physician: _____ Hospital Preference: _____

Insurance Company Policy No.: _____

Allergies to Medications: _____

Additional Information/Comments (i.e. blood transfusions, etc): _____

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