

**Office Use Only**

Registration Date: _____	Class 1 Name/Day/Time: _____
Registration Amount: _____	Class 2 Name/Day/Time: _____
Check # or Receipt #: _____	Class 3 Name/Day/Time: _____
Sibling Name: _____	Total Hours: _____ Tuition: _____

**2008-2009 Fall Registration**

Student's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
Birthday: \_\_\_\_\_ Age: \_\_\_\_\_ Grade in Fall: \_\_\_\_\_ Dismissal Time: \_\_\_\_\_  
Student's Academic School: \_\_\_\_\_  
Mom's Name: \_\_\_\_\_  
Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_  
Dad's Name: \_\_\_\_\_  
Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, and Zip: \_\_\_\_\_  
E-mail: \_\_\_\_\_  
Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_

**Previous Training**

Studio & City: \_\_\_\_\_  
Type of Dance: \_\_\_\_\_ Number of Years: \_\_\_\_\_

<b>Medical Information (All information will be kept confidential)</b>		
<b>Physical handicaps (specify handicaps, injuries, or weakness, etc.):</b>		
Bones and joints: _____		
Muscles: _____		
Eyes/Ears: _____		
Other: _____		
<b>Chronical ailments:</b>		
Asthma: _____	Respiratory: _____	Circulatory: _____
Heart: _____	Diabetes: _____	Epilepsy: _____
Hemophilia: _____	Other: _____	
<b>Psychological handicaps:</b>		
Anxiety: _____	Fears: _____	
Hyperactivity: _____	Hypersensitivity: _____	
Allergies: _____		
Family Physician: _____	Phone: _____	
Hospital: _____	Phone: _____	

**I AGREE TO ABIDE BY ALL OF THE STUDIO POLICIES AS OUTLINED ON THE POLICY SHEET. PLEASE SIGN BELOW THAT YOU HAVE READ AND UNDERSTAND THESE POLICIES:**

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_