Philly's Got Dance

Student Registration Form:

4226 Spruce Street ⭕

3359 Friendship St ⭕

STUDENT INFORMATION: **DATE:_____**

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

Nick Name: _____ Shirt Size _____

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: _____

2. Name: _____ Relationship to Child: _____

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

E-Mail: _____

Preferred way for receiving updates: check all that apply

Text (_____) Email (____)

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 PARTICIPATION: If your child is *ONLY* taking 1 class

Class Name (i.e. jazz, ballet, or hip-hop, gymnastics)

1. _____

How did you hear about our studio? _____

If referred, what is the parent and child(ren) name? _____

Previous Dance Training?

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

_____

_____

Is there anything that we should know about your child? (i.e allergies, shy)

_____

_____

_____

PAYMENT INFORMATION (Check One)

1 STYLE OF DANCE _____$40.00 Monthly

2 STYLES OF DANCE_____$50.00 Monthly (ages 3 to 5 ONLY)

3 STYLES OF DANCE _____$60.00 Monthly

1 STYLE w-Gymnastics _____$75.00 Monthly

3 STLYES +Gymnastics _____$95.00 Monthly

Gymnastics Only _____ $50.00 Monthly

Boys Hip Hop 6+ _____ $ 50.00 Monthly

Payment Plans:

Plan A: Payment on the 1st day of practice of every month, due prior to the start of class.

Plan B: Payment bi-weekly, due the 1st and 3rd week of class, prior to the start of class

Registration Fees:

New Student: $35 Returning Student: $20

Family: $50

(Plan A or Plan B)

I have chosen payment plan _____. Registration Fee: $_____ Monthly Tuition: $_____

I understand that one make-up class is permitted for each class my child misses. Make-up classes must be taken within 30 days at location of your choice. I also understand that all fees paid are nonrefundable and nontransferable. **There will be a $10 late fee charged PER week**. There is a $40 returned check fee.

PERSON RESPONSIBLE FOR PAYMENT:

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

RELATIONSHIP TO STUDENT: _____

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, hereby waive and release Philly's Got Dance Studio of Dance, Inc. and its staff 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 Philly's Got Dance. 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 hereby authorize LaVonda Jenkins or her designated agents (being teachers or administrators employed by Philly's Got Dance) 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 Philly's Dance 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: _____

EMERGENCY INFORMATION

Physician: _____ Hospital Preference: _____

Insurance Company Policy No.: _____

Allergies (food, medicine, etc): _____

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

_____