presents

Beginning Modern Class

On Mondays, June 8th, 15th, 29th and July 13th & 20th

Student Name ____________________

Address ____________________

City ____________________ **State** __________ **Zip** __________

Birthdate _____/_____/_____ **Age** ________ **Gender:** ☐ **M** ☐ **F**

Phone: Home __________ **Work** __________ **Cell** __________

Email ____________________

Guardian's Name (if under 18) ____________________

1. I am signing up for all five (5) classes in advance, prior to June 7th, at $50:

   ___________ Initials

2. I am signing up for all five (5) classes after June 7th at $60:

   ___________ Initials

3. I am signing up for individual class(es) at $12 per class:

   ___________ Initials Total $ ___________

   ☐ June 8
   ☐ June 15
   ☐ June 29
   ☐ July 13
   ☐ July 20

Charisma Centre for the Arts **Policy Statement**

Students of ***Charisma Centre for the Arts*** must agree with the following policies and sign a statement on the registration form to that effect:

I agree to adhere to the dress code for Charisma Centre for the Arts. I agree to be punctual for class. If I am sick or have a contagious condition, I will not attend class and will notify the instructor of my absence. I agree to contact the instructor if I am unable to attend for any reason. ***I understand that refunds and credits are not issued on missed classes or lessons.*** *As a student of* ***Charisma Centre for the Arts****, I agree and will adhere to the policy statements outlined in the CCA Handbook.*

____

Student/Guardian Signature and Date

For more information, please contact Daryse Osborne at 261-8440, ext. 227.

CHARISMA CENTRE FOR THE ARTS
Emergency Medical Authorization

Name of Student ____

Enrolled in: ____

Name of Emergency Contact ____

Phone (H) ____________________ (W) ____________________ (Cell) ____________________

____

Address City State Zip

In the event that I, as an adult student, am not able to respond and make a medical decision, or, in the event reasonable attempts to contact me (the guardian/parent) at home or work or

other parent at _________________________ have been unsuccessful, I HEREBY GIVE MY CONSENT for administration of any treatment deemed necessary by our physician

__________________________________ (name) at ______________________________ (phone) or

our dentist ________________________(name) at ______________________________ (phone). In the event our doctor or dentist is not available, transfer me/my child to

____ (preferred hospital), or any reasonably accessible hospital. FACTS CONCERNING MY/MY CHILD'S MEDICAL HISTORY, INCLUDING ALLERGIES, MEDICATIONS BEING TAKEN, AND ANY PHYSICAL CONDITIONS to which a physician should be alerted:

____

____

____

____

____

DATE

SIGNATURE of Student OR
SIGNATURE of parent or guardian if under 18 years of age

PEOPLE TO CONTACT IN EMERGENCY, IF PARENT CANNOT BE REACHED:

**Name: __________________________ Phone: (H) __________________ (W) __________________

Address: ____

Relationship to student: ____

**Name: __________________________ Phone: (H) __________________ (W) __________________

Address: ____

Relationship to student: ____