



## 2009 Summer Dance Intensive Registration Form

**Student Name** \_\_\_\_\_

**Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Birthdate** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Age** \_\_\_\_\_ **Gender:**  M  F

**Phone: Home** \_\_\_\_\_ **Work** \_\_\_\_\_ **Cell** \_\_\_\_\_

**Email** \_\_\_\_\_

**Guardian's Name (if under 18)** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Each participant must submit a separate registration form**

I will be attending the entire intensive:

- Early Bird postmarked by June 15 — \$65.00  
 After June 15— \$75.00

I will be participating on:

- Friday only  Saturday only \$45.00 per day

- I will pay by the class (must be registered by June 15) \$13.00 per class  
# of classes \_\_\_\_\_

Enclosed please find my check # \_\_\_\_\_ in the amount of \$ \_\_\_\_\_

I will be paying by credit card:  MC  VISA  
card # \_\_\_\_\_ Exp. Date \_\_\_\_\_

*\* I realize I need to be at the placement class on Thursday, August 13, at 7pm to be placed in any classes other than a beginner level. Initials \_\_\_\_\_*

*\* I am a returning student and will contact Daryse Osborne for placement. Initials \_\_\_\_\_*

I would like to present a piece for the Choreography Clinic.

Name of piece: \_\_\_\_\_

Length \_\_\_\_\_ minutes # of dancers \_\_\_\_\_

# **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: \_\_\_\_\_