

## West Chester Dance Expressions Student Registration Form: September 2023-June 2024

### **STUDENT INFORMATION**

Student's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_

### **PARENT/GUARDIAN INFORMATION**

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ (Mom/Dad/Other) \_\_\_\_\_

Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ (Mom/Dad/Other) \_\_\_\_\_

E-Mail: \_\_\_\_\_

### **EMERGENCY CONTACT**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

### **EMERGENCY INFORMATION**

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Company Policy No.: \_\_\_\_\_

Allergies/Medical Conditions (food, medicine, etc): \_\_\_\_\_

### **CLASS PARTICIPATION**

CLASS NAME	DAY/TIME	AMOUNT

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

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## **PAYMENT INFORMATION**

Payment Plans:

Plan A: Automatic credit card payment on the first of each month.

Credit Card Information:

\_\_\_\_\_ Visa \_\_\_\_\_ Mastercard \_\_\_\_\_ Other

Account Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

(3 digit on back of card): \_\_\_\_\_ Name as it appears on Card: \_\_\_\_\_

Signature of Cardholder: \_\_\_\_\_

Plan B: Check or cash payment at the first of each month. If not in by 5th of the month, a \$10 late fee will be assessed.

Plan C: Payment of tuition in full at registration to cover classes through May 2024 (no payment for June). 5% discount if paid in full.

Registration Fees: One-time fee: \$25

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 of the missed class(es). I also understand that all fees paid are nonrefundable and nontransferable. If my account becomes delinquent, my child will not be permitted to attend further classes, until my account is brought current. The parent or guardian is responsible for notifying, in writing, West Chester Dance Expressions of any change to the credit card or checking account. The returned check/declined card fee 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. Please be aware that credit card information you give us for this purpose ONLY will be kept on file until June 2024 when it will be shredded.*

## **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, diabetes, epilepsy, neurological condition, special medication, knee/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 West Chester Dance Expressions, 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 West Chester Dance Expressions, 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 hereby authorize West Chester Dance Expressions, Inc. or its designated agents (being teachers or administrators employed by West Chester Dance Expressions, 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 West Chester Dance Expressions, 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.

## **CONSENT OF RELEASE FOR PHOTOGRAPHS & INTERVIEWS**

Unless otherwise noted, as the parent or legal guardian of the student named, my signature below grants permission for my child or ward to be photographed, videotaped and/or interviewed during the course of the school year by WC Dance Expressions or any of its authorized agents, and consent for the publication, broadcast, or other use of the student's images and/or words for the purposes of promoting WC Dance Expressions. In addition, I, intending to be legally bound for myself, my heirs, executors and administrators, release WC Dance Expressions, or any parties acting on their behalf and with their approval, from liability for such uses of my child's or ward's images and/or words.

Please check for permission. \_\_\_\_\_ YES \_\_\_\_\_ NO

SIGNATURE OF PARENT/GUARDIAN: \_\_\_\_\_

DATE: \_\_\_\_\_

## **West Chester Dance Expressions**

**1155 Phoenixville Pike, Suite 111**

**West Chester, PA 19380**

**wcdanceexpressions@gmail.com**