

STUDENT INFORMATION

Student's Name: _____ Birth Date: _____

Home Address: _____ City: _____

Zip Code: _____ 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 to Child: _____ Phone: _____

EMERGENCY INFORMATION

Physician Name: _____ Phone: _____

Insurance Company Policy No.: _____

Allergies (food, medicine, etc): _____

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

CLASS PARTICIPATION

CLASS NAME	DAY/TIME	AMOUNT DUE

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

PAYMENT INFORMATION

Payment Plans:

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

Credit Card Information:

_____ Visa _____ Mastercard

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 June 2018 (pro-rated amount for last month of class). 5% discount if paid in full.

Registration Fees:

One-time fee: \$25

Second Family Member (siblings): \$15 Third/Fourth Family Member (siblings): \$0

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 2018 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

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