★ SUZETTE`S MASTERS OF DANCE ★

14275 Rick Dr. | Shelby Township | 48315 | 586.731.5454 |www.suzettesdance.com

2019-2020 NEW STUDENT____________ RETURNING STUDENT ____________

STUDENT NAME	
PARENT'S NAME	
ADDRESS	
CITY	ZIP CODE
EMAIL ADDRESS (IMPORTANT)	
HOME PHONE ( )	
MOTHER'S CELL PHONE/WORK ( )	
FATHER'S CELL PHONE/WORK ( )	

STUDENT #1 NAME	D.O.B	AGE	SEX M F

CLASS	DAY	TIME

<u>$25 REGISTRATION FEE PER FAMILY, $15 PER INDIVIDUALS. REGISTRATION FEE IS DUE UPON REGISTRATION. STUDENTS WILL NOT BE ENROLLED IN CLASSES UNTIL REGISTRATION FEE IS PAID FOR IN FULL.</u>

I HAVE READ, UNDERSTAND AND AGREE TO ALL OF THE PREVIOUS LISTED INFORMATION AND POLICIES OF SUZETTE`S MASTERS OF DANCE-SIGNATURE REQUIRED

SIGNATURE	DATE

RELEASE OF LIABILITY-SIGNATURE REQUIRED

As the legal parent or guardian, I release and hold Suzettes Masters of Dance and its owners and operators from any and all liability, claims, demands, and causes of action whatsoever, arising out of or related to any loss, damage, or injury, including death, that may be sustained by the participant and/or the undersigned, while in or upon the premises or any premises under the control and supervision of SMD and its owners and operators or in route to or from any of said premises. I also allow SMD to use photos and or videos for any advertising or publications. I have read and agree to follow Suzettes Masters of Dance Policies.

PARENT/GUARDIAN SIGNATURE	DATE

In the event of a serious accident or illness, I request that a representative of the dance studio contact me. If I cannot be reached, I request that contact is made with the physician named and their instructions be followed in the treatment of my child. If the emergency is such that immediate medical care is necessary, I authorize the dance studio to transport my child to the hospital for emergency care. The hospital agents, or a licensed physician, may administer such emergency treatment as they deem necessary under the circumstances.

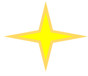
PARENT/GUARDIAN SIGNATURE	DATE

I do not give my consent for emergency medical treatment of my child. In the event of serious illness or injury requiring emergency treatment, I wish the dance studio to take no action or to:____

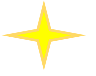
PARENT/GUARDIAN SIGNATURE	DATE

FOR OFFICE USE ONLY:

DATE REGISTERED AND PAID	PAYMENT TAKEN BY		
TUITION AMOUNT $	REGISTRATION FEE $		
TOTAL AMOUNT PAID $			
TYPE OF PAYMENT	CASH	CHECK #	CREDIT



EMERGENCY CONTACT SHEET



PARENT'S NAME			
STUDENT NAME	BIRTHDATE	AGE	SEX M F
ADDRESS			
CITY STATE	ZIP CODE		
EMAIL ADDRESS			
HOME PHONE ( )			
CELL PHONE/WORK ( )			

PLEASE LIST TWO EMERGENCY CONTACTS (OTHER THAN PARENTS)

NAME	PHONE	RELATION
NAME	PHONE	RELATION

MEDICAL INFORMATION

FAMILY DOCTOR	PHONE
MEDICATION TAKEN REGULARLY	
LIST ANY ALLERGIES	
DOES THE CHILD HAVE ASTHMA? Y N	INHALER TYPE
LIST PREVIOUS INJURIES THAT COULD BE OF CONCERN IN AN EMERGENCY	