DanceAble Adaptive Mini-Camp Registration form

Participant First Name: _____

Participant Last Name: _____

☐ Male ☐ Female Age (as of 07/01/2017): _____

Parent/Guardian 1 Name: _____ Parent/Guardian 2 Name: _____

Preferred Daytime Phone (1): _____Preferred Daytime Phone (2): _____

Preferred Email Address: _____

EMERGENCY OR NON-EMERGENCY AUTHORIZED PERSON (LOCAL) WHO CAN PICK UP PARTICIPANT

Contact Person 1: _____Phone: _____Relationship: _____

Family Physician (to be contacted): _____

Do you have medical insurance? ____Carrier: _____

Policy/Group #:_____

ALLERGIES

None Known ☐ Please list all known allergies below:

_____

_____

Please explain reaction and treatment for the above allergies:

_____

If medication will be provided, please fill out the Authorization to Administer Medication

CHILD HAS A HISTORY OF

Asthma ☐ Epilepsy ☐ Diabetes ☐ Autism ☐ Hyperactivity/Behavioral Issues ☐

Frequent Headaches ☐ Hearing Issue ☐

Other:_____

Please comment on indicated history:_____

***Please note you may be asked to meet with staff to discuss your child's medical history**

Signature of Parent/Guardian:_____ Date:_____

Please sign waiver and include with registration form, both can be mailed to:

602 Oak Street East Bridgewater Ma 02333 or Email: info@dancemsod.com