



Blossom Dance & Blossom Sisters Foundation

201-923-5498

www.blossomdance.com

www.blossomsistersfoundation.org

Student's Name:		Parent's Name:	
Contact No: Home: Mobile:	Date of Birth: / /		
Home Address:	E-mail address: _____ *(Required) Did you/child take dance before? _____ (If yes how long?) _____ Where and why did you leave?		
Class Information:			
Class #1 Course:	Day: _____	Time: _____	A.M. P.M.
Class #2 Course:	Day: _____	Time: _____	A.M. P.M.
Class #3 Course:	Day: _____	Time: _____	A.M. P.M.
Tuition Fees: <ul style="list-style-type: none">• 1 Classes \$48.00/mo.*2 Classes \$89.00. 8 Week (Ballet) \$95\ Teen Mentor Ages 12-17yr \$105.00 BSF Student Yes ___ No ___ Full Scholarship ___ Partial Scholarship ___ Rate \$ _____ Annual Registration Fee \$25.00			
Yearly Registration Fee: _____ Monthly Fee: _____ Total Due: _____ (Non Refundable Due to Reservation of Class /Time)			
Please check one: Cash ___ Check _____ (3 Digit on back of card) Check here for Auto Payment ___ Yes ___ No M/C Visa/Amex/Discover _____ EXP DATE _____ 3 Digit code ___			
Payment Policy: Please include payment for registration fee and tuition with completed registration form. Payments can be made at the studio or by mail. A late fee of \$ 15.00 per student will be assessed for payments received after the 7 th day of the month.			
Agree for Photography that will be taken during the school year for use by Blossom Dance only Yes_ No___			



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STUDENT LIABILITY WAIVER/PERMISSION FOR MEDICAL TREATMENT

In connection with the registration for your child for the dance classes and performances to be conducted by Blossom Dance\Blossom Sisters Foundation (BSF), and in consideration of your enrollment and/or consent of said child in such classes and/or performances. I/we the undersigned parent(s), acknowledge that I/we have been informed fully on the activities to be offered to said child and consent thereto: participation in the programs and performances to be offered by BD & BSF; acknowledges the risks and hazards of physical injury inherent with the classes and performances and hereby assume all risks and hazards; and I/we hereby release, waive and agree not to assert against BD & BSF each of its directors, teachers, employees or agents any claim to injury to said child in consequence of or incident to such training, performances and other activities.

Parents Signature _____ Date _____

In case of an emergency, if the staff of Blossom Dance & Blossom Sisters Foundation is unable to reach me/us by phone, or it is a situation that appears to require immediate emergency medial assistance, I/we herby give my/our permission for the staff to contact 911 emergency and secure treatments for my/our child as named in the emergency situation.

Name of Student's /Children: _____

Parent (s) or Legal Guardian Signature: _____ Date _____

Physician Name: _____ Phone: _____

In case of an emergency (please provide two contacts)

Emergency Name: _____ Phone: _____ Cell: _____

Emergency Name: _____ Phone: _____ Cell: _____

Health History (Please Circle)

1. Allergies: Bee Stings Penicillin Dairy/Products Nuts Other _____

2. Has your child been diagnosed with any of the following: (Please check)

TB ___ Heart Condition ___ Kidney Problems_ Diabetes___ Asthma___ Other_____

Special Needs: Please use space provided to share any health, behavioral, learning or other needs your may have that our staff needs to be aware of: **(All information is confidential)**

Transportation: My child has permission to ride with:

Name:	Relation:	Phone:	Cell:
Name:	Relation:	Phone:	Cell:
Name:	Relation:	Phone:	Cell:

Account# _____ (Office use only)