**Karar Academy**

**Student Registration Form**

**STUDENT(S) INFORMATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Student’s Name:** | **Birth Date:**  | **Age:**  | **Dance Experience? If yes, how long** | **Medical Concerns:** |
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**Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_**

**Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PARENT(S)/GUARDIAN(S) RESIDING WITH CHILD**

**1. Name: Relationship to Child:**

**Cell Phone: ( )\_ Work Phone: ( )\_**

**E-Mail: Place of Employment:**

**2. Name: Relationship to Child:**

**Cell Phone: ( )\_ Work Phone: ( )\_**

**E-Mail: Place of Employment:**

**ALL PERSONS AUTHORIZED TO PICK UP CHILD**

**1. Name: Relationship to Child: Phone:**

**2. Name: Relationship to Child: Phone:**

**3. Name: Relationship to Child: Phone:**

**CLASS PARTICIPATION**

**Class Name Day Time**

**1.**

**2.**

**3.**

**4.**

**How did you hear about our studio?**

**PAYMENT INFORMATION**

**Payment Plans:**

Plan A: Monthly Payments *(Cash, check, money order, debit/credit card* ***($2.00 convenience fee****))*

Plan B: Automatic bank account debit on the first of each month. Provide a voided check (no check cards or deposit slips).

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

Plan D: Payment of tuition in full at registration to cover classes through June 2015. *(Check, cash, or money order only).*

**Registration Fees:**

New Student: $25

Family: $40

**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****. The parent or guardian is responsible for notifying, in writing, Karar Academy Studio 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.*

PERSON RESPONSIBLE FOR PAYMENT:

PRINT NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WITNESS *(Must be at least 18 years of age)*:

 RELATIONSHIP TO STUDENT:

WITNESS *(Must*

**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, pregnancy, diabetes, epilepsy, chemical or neurological condition, special medication, knee/kidney/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 Karar Academy individually and Karar Academy 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 Karar Academy 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 Karar Academy or her designated agents (being teachers or administrators employed by Karar Academy) 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 Karar Academy 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.

SIGNATURE OF PARENT/GUARDIAN: DATE: WITNESS *(Must be at least 18 years of age)*: **EMERGENCY INFORMATION**

Physician: Hospital Preference: Insurance Company Policy No.: Allergies (food, medicine, etc.): Additional Information/Comments (i.e. blood transfusions, etc.):