MOVING MIRACLES
DANCE STUDIO
a division of sasi

personal TRAINING
a sasi program

MOVING MIRACLES DANCE & PERSONAL TRAINING
REGISTRATION FORM
Attachment A-1

PLEASE CHECK APPROPRIATE BOX FOR REGISTRATION: ☐ **DANCE** ☐ **PERSONAL TRAINING**
All information and forms in this packet must be completed and brought with you to the initial screening.

Participant's Name____Birth Date________________
Address____Phone________________________________
City/State____Zip_____________________________

Group Home____Manager/Contact____________________________
Address____Phone_________________________
City/State____Zip____________________________
Email Address of Contact Person____

Parent or Legal Guardian (circle which) ____
Address____Phone___________________________
City/State____Zip_____________________________
Email Address of Parent/Guardian____

To assist in ordering costumes, please provide clothing sizes:_____Pants____Shirts____Dress______Weight_____Height

PAYMENT*: Upon registration you will receive an invoice for the entire season, as well as a session confirmation. Trimester payments will be expected to keep the participant's account current.*

Address to which the invoice should be mailed:_____Participant's ____Contact Person's ____Legal Guardian's

I agree to assume responsibility for payment of sessions. ____
Signature / Relationship to Participant

NOTE: The safety of every participant and staff, without question, takes precedence in the studio. If your participant requires additional supports, it is your responsibility to provide the required level of support each and every week.
If a participant demonstrates consistent behavior that is a threat to self or others, it is our policy that he/she will be suspended/dismissed from the program until it can be proven that these behaviors are under control.
Also it is mandatory a parent, caregiver or staff remain in the dance studio facility throughout each session.
Thank you for your cooperation in keeping the studio a safe environment for everyone.

Key words/Behaviors/Special Needs that are important for our staff to know:
____
____

I understand the above and am in agreement with this policy: ____
Signature / Relationship to Participant / Date

MOVING MIRACLES
DANCE STUDIO
a division of sasi

personal TRAINING
a sasi program

MOVING MIRACLES DANCE & PERSONAL TRAINING

PARENT/CAREGIVER REGISTRATION FORM

Attachment A-2

NAME:____ BIRTH DATE:__________________

PARENT/GUARDIAN/CARE PROVIDER:____

ADDRESS:_________________________________CITY/STATE/ZIP:________________________

HOME PHONE:________________WORK PHONE:__________________CELL PHONE:____________

EMERGENCY CONTACT:_________________________________PHONE:___________________

IT IS IMPORTANT THAT THIS INFORMATION IS ACCURATE. INCORRECT OR INCOMPLETE INFORMATION MAY JEOPARDIZE THE SAFETY OF THE PARTICIPANT

DIAGNOSES: ____
____

MEDICAL/SURGICAL HISTORY:____

CURRENT MEDICATIONS:____

ADAPTIVE EQUIPMENT:____

DOES THE PARTICIPANT RECEIVE OT / PT SERVICES? IF SO, WITH WHICH AGENCY:__________________

ABILITY: ('x' in box)	FULL ASSIST	MINIMAL ASSIST	SUPERVISION	INDEPENDENT
Stair Climbing				
Walking				
Transferring				
ADL Skills				
BALANCING:	POOR	FAIR	GOOD	NO IMPAIRMENT
While Seated				
While Standing				
While Moving				
MOTOR SKILLS:	POOR	FAIR	GOOD	NO IMPAIRMENT
Head Control				
Trunk Control				
Grip				
Muscle Strength				
VISION: (check one)	No ability ☐	Wears Glasses ☐	No impairment ☐	
HEARING:	No ability ☐	Wears Hearing Aid ☐	No impairment ☐	
SPEECH:	No ability ☐	Uses Sign ☐	Some Speech ☐	No impairment ☐

ADDITIONAL INFORMAITON: TACTILE DEFENSIVE? ☐ Yes ☐ No
SENSORY IMAPAIRMENT? ☐ Yes ☐ No
IMPAIRED PERCEPTION ☐ Yes ☐ No

WHAT ARE YOUR ANTICIPATED GOALS FROM PARTICIPATION IN THE PROGRAM?

____

personal TRAINING
a sasi program

MOVING MIRACLES DANCE & PERSONAL TRAINING
AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT
Attachment A-3

Participant's Name: ____

Physician's Name:_______________________________ Phone:_______________

Preferred Medical Facility:__________________________ Phone:_______________

Health Insurance Company:_________________________ Phone:_______________

List all pertinent medical information (allergies to food or drugs, special medical conditions):

____

____

SELECT ONE:

CONSENT PLAN

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Suburban Adult Services, Inc. to:

1. Secure and retain medical treatment and transportation if needed.
2. Release participant's records upon request to the authorized individual or agency involved in the medical emergency treatment.

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the contacts listed above are unable to be reached.

____

CONSENT SIGNATURE DATE

NON-CONSENT PLAN

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of Suburban Adult Services, Inc. In the event emergency treatment is required, I wish the following procedures to take place:

____

____

____

____

NON-CONSENT SIGNATURE DATE

LIABILITY RELEASE: ________________________ **(Participant's Name) would like to participate in the sasi moving miracles dance/exercise program. I acknowledge the risks and potential for injury during any dance/exercise program. However, I feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors, or administrators, waive and release forever all claims for damages against Suburban Adult Services, Inc., its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in the sasi moving miracles dance/exercise program.**

Date:______________________ Signature: ______________________________________

Parent / Guardian / Correspondent / or Self (if over 21, no guardian)

PHOTO RELEASE: I hereby consent to and authorize the use and reproduction by Suburban Adult Services, Inc., of any and all photographs and any other audio / visual materials taken of me/my son/my daughter/ my ward for promotional printed material, social media or for any other use for the benefit of the program. ☐ Yes ☐ No

I understand that if a student cannot be photographed or videotaped for any reason, this obligates the above named student to be enrolled in a private lesson at an increased tuition rate of $85/month.

Date:______________________ Signature: ______________________________________

Parent / Guardian / Correspondent / or Self (if over 21, no guardian)

personal TRAINING
a sasi program

MOVING MIRACLES DANCE & PERSONAL TRAINING

PHYSICIAN'S RELEASE
Attachment A-4

Dear Dr.________________________________, the individual listed below has indicated that you are their primary physician. They have shown an interest in participating in a moderate level dance/exercise program. Please provide us with your recommendations regarding the dance/exercise prescription for this individual and any restrictions and/or limitations that would limit their participation in this program. Thank you for your cooperation.

Participant's name: ____

Diagnoses: ____

(Please check all that apply)
1. Are there any limitations to this individual's mobility or biomechanics? ☐ Yes ☐ No
If yes, please describe: ____
____

3. Are there any limitations to any Training Techniques, Cardiovascular and/or Endurance exercises?
Group training - (calisthenics, skipping, jogging running) ____
Endurance recumbent stepper - (elliptical with wheelchair accessibility) ____
Dance - (total body movement) ____

Physician's Recommendation

____ **I am not aware of any contraindications in participating in this dance or personal training program.**

____ **I believe this individual can participate, but urge caution because:**
____

____ **This individual should NOT participate in the following activities:**
____

____ **I recommend this individual NOT participate in the dance or personal training program.**

Please specify any other restrictions or limitations you feel are appropriate.
____
____

Physician's Electronic Signature & Stamped Address Required **Date:** ______________________

____
Name (Please Print) **Signature**

____
Address **Phone Number**

Moving Miracles
954 Union Road, Suite 1
West Seneca, NY 14224

Phone: (716) 656-1321
Fax: (716) 771-3688
Email:info@movingmiracles.org