



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. Monthly 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 know:

I understand the above and am in agreement with this policy: _____

Signature / Relationship to Participant / Date



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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)	<u>FULL ASSIST</u>	<u>MINIMAL ASSIST</u>	<u>SUPERVISION</u>	<u>INDEPENDENT</u>
Stair Climbing				
Walking				
Transferring				
ADL Skills				
BALANCING:	<u>POOR</u>	<u>FAIR</u>	<u>GOOD</u>	<u>NO IMPAIRMENT</u>
While Seated				
While Standing				
While Moving				
MOTOR SKILLS:	<u>POOR</u>	<u>FAIR</u>	<u>GOOD</u>	<u>NO IMPAIRMENT</u>
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 INFORMATION: TACTILE DEFENSIVE? Yes No
SENSORY IMPAIRMENT? Yes No
IMPAIRED PERCEPTION Yes No

WHAT ARE YOUR ANTICIPATED GOALS FROM PARTICIPATION IN THE PROGRAM?



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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**