MOVING MIRACLES
REGISTRATION FORM A-1

All information and forms in this packet must be completed and brought with you to the initial screening.

Participant's Name ____Birth Date________________

Birth Date_________________________ Weight _____________ Height ________________________________

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

TUITION/PAYMENT*:*
Will the person be utilizing self-direction for tuition? YES NO
If yes, please provide the name and contact information of the Support Broker and Fiscal Intermediary:

Name_____________________________ Phone_____________________ Email________________________

Name_____________________________ Phone_____________________ Email________________________

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

Payment preference for the season (check one): Monthly Calendar Year Full Payment

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

NOTE: The safety of every participant and staff, takes precedence in the studio. If your participant requires additional supports, it is your responsibility to provide the required level of support 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

MOVING MIRACLES
PARENT/CAREGIVER REGISTRATION FORM A-2

NAME: ______________________________ BIRTH DATE: ______________

PARENT/GUARDIAN/CARE PROVIDER: ______________________________

ADDRESS: ______________________________ CITY/STATE/ZIP: ______________

HOME PHONE: ______________ WORK PHONE: ______________ CELL PHONE: ______________

EMERGENCY CONTACT: ______________________________ PHONE: ______________

*** 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 you anticipated goals from participation in the program?
____
____

MOVING MIRACLES

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT 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 sasi 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 sasi. In the event emergency treatment is required, I wish the following procedures to take place:

____

____

____

____

____

NON-CONSENT SIGNATURE **DATE**

<u>LIABILITY RELASE</u>: ________________________ (participant's name) would like to participate in the sasi Moving Miracles dance program. I acknowledge the risks and potential for injury during any portion of the dance program. My participation is voluntary. The dance program does not provide supports or supervision I may otherwise need thus I am always responsible for all my support needs and protections while at the program. I understand the dance program has not made any assessment of my physical or emotional ability to participate. 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 sasi, 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 program.

Date: ______________________ Signature: ____

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

<u>PHOTO RELEASE:</u> I hereby consent to and authorize the use and reproduction by sasi, of any and all photographs and any other audio / visual materials taken of me/my son/my daughter/ my ward for promotional printed material, educational activities or for any other use for the benefit of the program.

Date: ______________________ Signature: ____

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

a division of sasi

MOVING MIRACLES
DANCE STUDIO

MOVING MIRACLES
PHYSICIAN'S RELEASE A-4

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

Participant's name: ____

Diagnoses: ____

1. Are there any limitations to this person's mobility or biomechanics? Yes ☐ No ☐

   If yes, please describe: ____
   ____

2. Are there any limitations to any Training Techniques, Cardiovascular and/or Endurance exercises?

   Dance - (total body movement) ___

Physician's Recommendation

____ I am not aware of any contraindications in participating in this dance program.

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

____ This person should NOT participate in the following activities:
____

____ I recommend this person NOT participate in the dance 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

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MOVING MIRACLES
DANCE STUDIO

CLASS PREFERENCE A-5

Dancer Name: ____

- Season runs September-May
- Group classes are 45 minutes.
- Solo classes are 30 minutes.

Please check one:

- ☐ 1 Non-Performing Class ($660)
- ☐ 1 Group Performance Class ($750)
- ☐ 2 Group Performance Classes ($1,350)
- ☐ 1 Group Performance, 1 Solo Performance ($1,350)
- ☐ 1 Group Performance, 1 Solo Non-Performance ($1,269)
- ☐ 3 Group Performance Classes ($1,890)
- ☐ 2 Group Performance Classes, 1 Solo Performance ($1,890)

Please select dancer's available days (check all that apply):

- ☐ Monday
- ☐ Tuesday
- ☐ Wednesday
- ☐ Thursday
- ☐ Saturday

Additional Notes:

____
____
____
____
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____
____
____
____
____