

MOVING MIRACLES REGISTRATION FORM A-1

All information and forms in this	nackat must be completed	and brought with	you to the initial careening
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Participant's Name		Birth Date		
Address			Phone	
City/State				
Group Home		Man	ager/Contact	
Address			Phone	
City/State			Zip	
Email Address of Contact Person				
Parent or Legal Guardian (circle wh	ich)			
Address			Phone	
City/State				
Email Address of Parent/Guardian_				
To assist in ordering costumes, plea	ase provide clothin	g sizes:Pan	tsShirtsDress	WeightHeight
TUITION/PAYMENT: Will the person be utilizing self-dired If yes, please provide the name and				ediary:
Name	Phone_		Email	
Name	Phone_		Email	
Address to which the invoice sho	uld 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 f	or payment of se	ssions.		
		Signature / Relationship to Participant		
NOTE: The safety of every participation	ant and staff, take	s precedence in tl	ne studio. If your participa	int requires additional

supports, it <u>is your responsibility</u> 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: _



<u>MOVING MIRACLES</u> PARENT/CAREGIVER REGISTRATION FORM A-2

NAME:	BIRTH DATE:		
PARENT/GUARDIAN/CARE PROVIDE	R:		
ADDRESS:	CITY/STATE/ZIP:		
HOME PHONE:	WORK PHONE:	CELL PHONE:	
EMERGENCY CONTACT: * INCORRECT OR INCOMPLETE INFOI	PHONE: FORMATION MAY JEOPARDIZE THE SAFETY OF THE PARTICIPANT*		
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 INFORM	IAITON: 7	TACTILE DEFENSIVE	Yes No	
	S	SENSORY IMAPAIRMENT	Yes No	
	Ι	MPAIRED 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 dru	gs, 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.

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:

CONSENT SIGNATURE

DATE

NON-CONSENT SIGNATURE DATE

LIABILITY RELASE:

(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)

PHOTO RELEASE: Denial of agreement to photo consent will result in student being placed in a non-performing class. 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)



MOVING MIRACLES PHYSICIAN'S RELEASE A-4

Dear Dr, the person listed below has indicated that you are their primary obysician. They have shown an interest in participating in a moderate level dance program. Please provide us with your ecommendations 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:
Are there any limitations to this person's mobility or biomechanics? Yes \Box No \Box
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



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):

- \Box Monday
- □ Tuesday
- □ Wednesday
- □ Thursday
- □ Saturday

Additional Notes: