



MOVING MIRACLES
DANCE STUDIO

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 _____

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



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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)	<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 you anticipated goals from participation in the program?



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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.

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 RELEASE: _____ (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)



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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



MOVING MIRACLES
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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 (\$765)
- ☐ 1 Group Performance Class (\$765)
- ☐ 2 Group Performance Classes (\$1,377)
- ☐ 1 Group Performance, 1 Solo Performance (\$1,377)
- ☐ 1 Group Performance, 1 Solo Non-Performance (\$1,269)
- ☐ 3 Group Performance Classes (\$2,019.60)
- ☐ 2 Group Performance Classes, 1 Solo Performance (\$2,019.60)
- ☐ 4 Performance Classes (please speak to Macey for solo/duet/group configuration): \$2,601

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

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

Additional Notes:
