

# Y-Dance Registration Form

## *Child's Information:*

Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Grade: \_\_\_\_\_ (if summer, indicate grade going into)

## *Parent's Information:*

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Main Phone #: (        ) \_\_\_\_\_ - \_\_\_\_\_

Parent/Guardian Cell Phone # (        ) \_\_\_\_\_ - \_\_\_\_\_

Parent/Guardian Cell Phone # (        ) \_\_\_\_\_ - \_\_\_\_\_

Dance Student Cell Phone # (        ) \_\_\_\_\_ - \_\_\_\_\_

Email: \_\_\_\_\_

*Parent/Guardian*

Email: \_\_\_\_\_

*Dance Student*

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**Health History:** (check and give approximate dates)

Frequent ear infections \_\_\_\_\_ Heart Defect/ Disease \_\_\_\_\_ Seizure Disorders \_\_\_\_\_ Diabetes \_\_\_\_\_

Bleeding/Clotting Disorders \_\_\_\_\_ Tetanus (dates) \_\_\_\_\_

**Diseases:**

Chicken Pox \_\_\_\_\_ Measles \_\_\_\_\_ German Measles \_\_\_\_\_ Mumps \_\_\_\_\_ Asthma \_\_\_\_\_

**Allergies:**

Hay Fever \_\_\_\_\_ Poison Ivy \_\_\_\_\_ Insect Stings \_\_\_\_\_ Other Allergies: \_\_\_\_\_

**Health Data:** (add additional sheet if necessary)

Operations or Serious Injuries \_\_\_\_\_ Chronic Illness \_\_\_\_\_ Dietary restrictions \_\_\_\_\_

Current Medications \_\_\_\_\_

Name of Physician \_\_\_\_\_ Phone \_\_\_\_\_ Name of Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Special Needs: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Parent Authorization:** I hereby do declare my child to be physically sound, having medical approval to participate in the activities of the YWCA. The health history is correct so far as I know, and the person herein described has permission to engage in all prescribed program activities except as noted. I further understand that neither the YWCA nor any of its paid staff or volunteer workers can be held responsible in the event of an accident. I certify that my child is amenable to discipline and free from habits or attitudes, which would make him/her an undesirable participant. I have studied the brochure and fees and understand the contents thereof. Yes \_\_\_\_\_ No \_\_\_\_\_

**Photo Permission:** I authorize the YWCA and/or news media to photograph/videotape my child in YWCA activities. Yes \_\_\_\_\_ No \_\_\_\_\_

**Emergency Authorization:** I authorize any representative of the YWCA to seek medical attention for my child when immediate medical care is warranted by the circumstances and I cannot be reached, or if under the circumstances there is no time to attempt to reach me because of the nature of the injury or illness. I further authorize the health care professional selected by the YWCA to provide necessary care and treatment to my child. Yes \_\_\_\_\_ No \_\_\_\_\_

Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_