

Medical
Parental

Student Information

Last Name _____ First Name _____ Middle Initial _____ Sex _____
 Birthdate ____/____/____ Home Phone: _____
 Address _____ City _____ Zip _____

Mother's Information: Resides with Student: Yes No If address is different is an extra mailing requested: Yes No
 Last Name: _____ First Name: **Mrs/Ms** _____ Home Phone: _____
 Street Address: _____ City _____ State: ____ Zip Code: _____
 Cell Phone: _____ Work Phone: _____

Father's Information: Resides with Student: Yes No If address is different is an extra mailing requested: Yes No
 Last Name: _____ First Name: _____ Home Phone: _____
 Street Address: _____ City _____ State: ____ Zip Code: _____
 Cell Phone: _____ Work Phone: _____

Emergency Contacts – (If parents can not be reached, list in order next contacts.)

1. Last Name: _____ First Name: _____ Relationship to student: _____
 Home Phone: _____ Cell: _____

#2. Last Name: _____ First Name: _____ Relationship to student: _____
 Home Phone: _____ Cell: _____

STUDENT HEALTH CONCERNS:

Does your child have any of the following medical conditions that the studio should be aware of?

	Yes	No		Yes	No		Yes	No
Asthma			Epilepsy			Diabetes		
Heart Condition			Other:			Other:		

Medications and Allergies: Please list below:

In case of accident or serious illness, I request the studio contact me. If the studio is unable to contact me, I hereby authorize, that the studio may make whatever arrangements deem necessary. I agree to assume financial responsibility for these emergency referrals (This includes hospital, medical and ambulance services).

STUDIO RULES ACKNOWLEDGE

We acknowledge that we will review the studio rules and follow them at all times.

(Student's Signature) **(Date)**

(Parent's Signature) **(Date)**