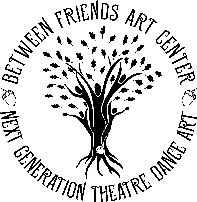
****

**REGISTRATION**

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ guardian of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ,

(Adult/Guardian) (Student Name)

RELEASE BETWEEN FRIENDS ART CENTER, AND ANYONE AFFILIATED WITH BETWEEN FRIENDS ART CENTER: HOME OF NEXT GENERATION FROM ANY LIABILITY FROM ANY ACCIDENT OR INJURY WHICH MAY OCCUR DURING NORMAL CLASS ACTIVITIES. ALL STUDENTS WILL BE SUPERVISED DURING CLASS TIME AND WILL BE EXPECTED TO FOLLOW THE DIRECTIONS GIVEN BY THE INSTUCTOR(S) TO ASSURE EACH STUDENT’S SAFETY. I UNDERSTAND THAT I/WE ARE COMMITTING TO THE FULL SESSION FOR EACH PROGRAM.

UPON DISCONTINUED ATTENDANCE FOR ANY REASON ALL PAYMENTS AND UNUSED CREDITS WILL BE FORFEITED.

DEPOSITS, TUITION, COSTUME FEES, ADDITIONAL EXPENSES AND CLASSES CANCELLED DUE TO WEATHER WILL NOT BE REFUNDED.

INCREMENTAL $5 LATE FEES WILL APPLY TO ALL CLASSES AND COSTUME BALANCES 7 DAYS, 14 DAYS AND ONE MONTH PAST THE DUE DATE.

CHECKS RETURNED WILL NEED TO BE PAID WITHIN 1 WEEK OF RETURN WITH AN ADDITIONAL $30 BANK CHARGE.

CLASSROOM PHOTOS AND/OR NAME OF STUDENT MAY BE USED IN BETWEEN FRIENDS AND NEXT GENERATION SOCIAL MEDIA, PERFORMANCE POSTERS AND COMMUNITY MARKETING. PLEASE LET US KNOW OF ANY CONCERNS.

BY SIGNING BELOW, I AGREE TO ALL OF THE ABOVE.

ADULT/GUARDIAN SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

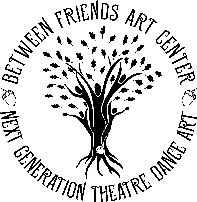
CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP CODE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-MAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDITIONAL INFORMATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Above information is held in confidence.***

**CONSENT FOR EMERGENCY TREATMENT**

STUDENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I HEREBY GIVE PERMISSION FOR MYSELF/STUDENT TO BE GIVEN EMERGENCY TREATMENT (FIRST AID OR CPR) BY A QUALIFIED STAFF MEMBER IF AVAILABLE.

I GIVE PERMISSION FOR MYSELF/STUDENT TO BE TRANSPORTED BY AMBULANCE TO AN EMERGENCY CENTER AND TREATED BY EMT STAFF AS NEEDED IN THE CASE OF AN EMERGENCY THAT CAN NOT BE HANDLED AT THE ARTS CENTER AND DEEMED NECESSARY BY THE STAFF.

IN THE EVENT THAT I CANNOT BE CONTACTED, I FURTHER CONSENT TO THE MEDICAL/HOSPITAL CARE TREATMENT AND PROCEDURES TO BE PERFORMED BY A LICENSED PHYSICIAN OR HOSPITAL WHEN DEEMED IMMEDIATELY NECESSARY OR ADVISABLE BY THE PHYSICIAN TO SAFEGUARD MY/MY STUDENT’S HEALTH.

IN THE CASE OF AN EMERGENCY WHERE MYSELF/STUDENT REQUIRES EMERGENCY TREATMENT AND/OR TRANSPORTATION I AGREE TO PAYALLCOSTS INVOLVED EITHER WITH INSURANCE OR PRIVATELY.

ADULT/GUARDIAN NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME PHONE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEALTH CONDITIONS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICATIONS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALLERGIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INFORMATION THAT MIGHT BE NEEDED IF AN EMERGENCY ARISES**

EMERGENCY CONTACT NAME (IF YOU CANNOT BE REACHED): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATION TO STUDENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BELOW IS OPTIONAL**

PHYSICIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHYSICIAN PHONE #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PREFERRED HOSPITAL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_