



Lorraine Cranford
Summer Dance Workshop
June 4-6, 2017

REGISTRATION FORM

Please complete both this Registration Form and the Medical Information and Release Agreement Form and return with your \$50 non-refundable deposit to:

Western Arkansas Ballet
Lorraine Cranford Summer Dance Workshop
4701 Grand Avenue
Fort Smith, AR 72904

Parent/Guardian's Name: _____

Dancer's Name (please print): _____

Age: _____ Birth Date: ____/____/____ Gender (circle one): M / F

Address: _____ T-Shirt Size: _____

Home Phone: _____ Cell Phone: _____

Dance School: _____

Years studied: _____ Instructor: _____

Students must be 11 years of age or older and have at least two years of classical ballet training.

LORRAINE CRANFORD SUMMER DANCE WORKSHOP

Medical Information and Release Agreement Form

Name: _____

Age: _____ Birth date: ____ / ____ / ____

Home Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Doctor's Name: _____ Doctor's Phone: _____

Hospital: _____ Hospital Phone: _____

Insurance Company: _____ Insurance Phone: _____

Policy Number: _____

In case of an emergency, I give LCSDW permission to seek medical help for

Dancer's Name (please print)

Parent/Guardian's Signature

Date

Does your child have any allergies? Yes _____ No _____

If yes, explain: _____

Does your child have any current injuries preventing 100% participation? Yes _____ No _____

If yes, explain: _____

My child has permission to take: Aspirin _____ Tylenol _____ Advil _____ Other _____

In case of emergency call:

Name: _____ Phone: _____

The undersigned has adequate health and medical insurance coverage and will not look to Western Arkansas Ballet or LCSDW in any way whatsoever for any damage, injury, or claim which might arise out of his/her participation in LCSDW dance activities.

Dancer's Name (Please Print)

Parent/Guardian's Signature

Date