KMS Dance 2025-2026

CLINIC REGISTRATION FORM

Participant's Name:_____

DOB:_____ Age:_____

Address:_____

City:_____ State:_____ Zip:_____

Parent/Legal Guardian's Name:_____

Home Phone:_____ Parent Cell:_____

Parent/Guardian Email:_____

Current School:_____ Grade Level:_____

IN CASE OF EMERGENCY

Contact #1

Name:_____

Phone:_____

Relation:_____

Contact #2

Name:_____

Phone:_____

Relation:_____

PARTICIPANT'S MEDICAL/ALLERGY CONDITIONS:

_____

*Medications cannot be given to any child

****Please attach any accommodations that should be considered from a current 504/IEP**

INTERNAL USE ONLY-To be filled out by Coach

Payment Type:_____ Amount Paid:_____