

Registration forms may be mailed with payment to:
San Diego Civic Youth Ballet
2125 Park Blvd., San Diego, CA 92101

Class Registration for SDCYB Summer 2010 July 6th – August 28th **Level 1A, Beginning Ballet, & Beginning Teen**

Dancer's Name: _____ Birth date: _____

Address: _____

City: _____ Zip _____

Phone #: Home: _____

Guardian's name(s): _____

Cell(Mom): _____ Cell(Dad): _____

Work(Mom): _____ Work(Dad): _____

Guardian E-mail: _____

* SDCYB will NOT give out your email. SDCYB prefers to be able to email families with updates and announcements.

Level 1A

Monday 5:00-6:00pm
 Tuesday 4:00-5:00pm
 Saturday 9:00-10:00am

Beginning Ballet (Age 7-10)

Thursday 4:00-5:00pm

Beginning Teen

Wednesday 7:00-8:00pm

Tuition

*\$10 discount if registered & paid in full within the first week that registration opens(One per family please)
Sibling Discount: 10% off tuition for second (third, fourth, etc.) child*

\$85 one class per week

\$130 two classes per week

*****Policies:**

- There will be a **\$25 late fee** if tuition is not paid by the end of the 1st week of classes
- The first week of the registration period for each session will be a pre-registration week for currently enrolled students only

Please read *carefully*, ask for any clarification and sign for your agreement to these policies:

I understand that:

- There are NO refunds or credits – no refunds for missed classes but a makeup class at a different class time may be scheduled.
- Dancers must comply with the required # of classes at their level to participate in productions
- My child and I agree to the terms of the SDCYB Parent / Student Handbook

Guardian Signature: _____ Date _____

I give my permission for my child's image to be used by SDCYB (no names). Yes:___ No:___

Office use:

Payment: _____ Ck#/Cash: _____ Receipt # _____ Balance: _____ Date: _____

Payment: _____ Ck#/Cash: _____ Receipt # _____ Balance: _____ Date: _____

Payment: _____ Ck#/Cash: _____ Receipt # _____ Balance: _____ Date: _____

Medical History & Emergency Consent Form

Student Name (Please Print): _____

Please provide below information that will help our staff obtain medical assistance for your child in the case of accident or illness.

1. Are they currently receiving, or have they recently received any medical or psychological care, or any other treatment, of which you want us to be aware in case of an emergency? If so, describe fully.

2. What medications or other substances are they allergic to?

3. Are there any medications they are currently taking that SDCYB staff should be aware of?

4. Do you have a physician who should be consulted in case of an emergency? If so, list below.

Physician Name Phone (____) ____-____ Ext. _____

5. Insurance Company: _____ Policy #: _____

5. Please provide an emergency contact: _____
Phone (daytime): _____ Phone (Cell): _____

MEDICATION ADMINISTRATION

Non-prescription Medication listed below is available in the Clinic for parents to request for their child. This medication is given *after* initial evaluation of your child's symptoms. All medications are given in accordance with the packaging label on the product, by age and weight-appropriate strengths. I hereby authorize SDCYB staff to administer medication checked below to my child while at SDCYB.

- No medications may be administered
- Acetaminophen (e.g. Tylenol) for fever or pain
- Antibiotic ointment (e.g. Neosporin) for cuts and scrapes
- Throat Lozenges (e.g. Halls cough drops)
- Benadryl Liquid (for severe allergic reactions)
- Ibuprofen (e.g. Advil, Motrin) for fever or pain

I (we) the undersigned parent(s) or guardian(s) of _____

a minor, do hereby authorize and consent to an X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable and is to be rendered under the general or special supervision of any medical or emergency room staff licensed under the provisions of the Medical Practice Act. I (we) agree to accept responsibility for all costs incurred from the rendering of needed emergency services for my (our) child.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide consent to such care when the foregoing licensed physician in his/her best judgment deems it advisable. It is understood that the hospital shall attempt to contact the undersigned and the physician identified above if one is noted, prior to rendering treatment to the minor or dependent adult.

In the event that I (we) can not be reached, my (our) authorization is given to the responsible party from SDCYB to secure proper treatment for my child named above.

I (we) agree to save and hold the officers, employees, or agents of the San Diego Civic Youth Ballet and the medical care providers harmless from all liability, suits, or claims, of whatever nature or kind which might arise as a result of administering needed emergency care.

Guardian Signature: _____ **Date:** _____