Calling all DANCERS!

You are invited to attend the

Foothill Knights Dance Team Summer Clinic

June 26th – 29th 2018

9:00am - 2:00pm Tuesday-Friday

Final Performance
1:00pm Friday, June 29th

Open to grades incoming K thru 8th

Registration $175 Before June 1st
($200 after June 1st)

Price includes T-Shirt and Tote Bag
*** (Poms can be ordered for an additional $12)**

Taught by:
Foothill High School's Dance Team & Coach Marrissa

RESERVE your SPOT TODAY
please contact: Jo Hodgetts (714) 271-5666
or *email: FHSdanceknights@gmail.com*

FHS Dance & Pom Clinic Registration

Tuesday June 26th – June 29th, 2018
9:00 am to 2:00 pm
Foothill High School
19251 Dodge Ave., Santa Ana, CA 92705

Registration/Check-In: 8:30 am Tuesday, June 26th

Final Performance: 1:00 pm Friday, June 29th at FHS
(Parents, Grandparents, Friends & Family Welcome)

Please make your non-refundable payment of $175.00 ($200.00 after June 1st) to FHS DANCE BOOSTERS and return it with your completed Registration Form and Medical Information*** to:

FHS Dance Boosters
C/O 10652 Villa del Cerro
Santa Ana, CA 92705

Student: _____T-Shirt size: YXS YS YM YL AS
Parent: _____
Home Phone: _____ Cell Phone: _____
Address: _____City: _____ Zip: _____
School: _____Grade in Fall 2018: _____
Email: _____

Dancers: please bring your own lunch, or see below to order a pizza meal.
Additional snack bar items available for cash only purchase.

Pizza Lunch ($5.00/day for 2 slices & drink) Please indicate Cheese or Pepperoni	Tues	Wed	Thurs	Fri
	Ch/Pep	Ch/Pep	Ch/Pep	Ch/Pep

Registration Fee: $175 (before June 1st) _____

Registration Fee: $200 (after June 1st) _____

Returning Dancer: $10 Discount _____

Sibling: $20 Discount for 2nd Dancer _____

Poms: $12 (required for clinic) _____

Lunch: $5/day # of Days _____

Total: _____

_____Yes, I give permission for my daughter to be photographed.

_____No, I do not give permission for my daughter to be photographed.

MEDICAL TREATMENT INFORMATION

It is required that this information be on file at the camp in case of an emergency. No participation will be allowed if the Medical Treatment Information is not provided.

Name: _____ Birthdate: ____/_____/_____
Mother's Name: _____
Day Phone: _____Cell Phone: _____
Father's Name: _____
Day Phone: _____Cell Phone: _____
Relative or friend to contact in case of an emergency (other than parent or guardian):
Name: _____Relationship: _____

Day Phone: _____
Health Insurance Company: _____
Policy Number: _____
Family Doctor: _____ Phone: _____

Has participant had any serious illness or surgery? Yes / No
If yes, describe nature and date: _____
_____
Does participant have any medical problems which may interfere with camp activities? Yes / No
If yes, give brief explanation: _____
_____

ASSUMPTION OF RISK

The undersigned hereby acknowledges that he/she knowingly and voluntarily assumes all risks of bodily injury to his/her child, as stated, and expressly acknowledges their intention, by executing this instrument, to exempt and relieve the Tustin Unified School District (District), its officers, agents and employees, from any liability for personal injury, bodily injury, property damage or wrongful death that may arise out of or in any way be connected with the above-described activity. I have read the foregoing and have voluntarily signed this agreement. I am aware of the potential risks involved in this activity and I am fully aware of the legal consequences of signing this instrument. I further acknowledge that the District does not provide liability insurance for this program, nor does the District provide medical coverage for participants in the activity.

AUTHORIZATION TO TREAT A MINOR

I (We) the undersigned parent(s)/legal guardian of _____, a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medicine Practice Act or a Dentist licensed under the provisions of the Dental Practice Act and on the staff of any emergency general hospital holding a current license to operate a hospital from the State of California Department of Public Health. 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 authority and power to render care which the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

Signature of Parent or Guardian: _____ Date: _____

Student's Signature: _____ Date: _____

***Note: Please complete a separate Registration & Medical Form for each Dancer.**