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----------DABKE REGISTRATION FORM----------

___ New **___ Returning**

APPLICANT INFORMATION

Name: _____ **Grade:** _____ **Age:** _____

Home Address: _____ **City:** _____

Zip Code: _____ **Home Phone Number:** _____

EMERGENCY CONTACT - PARENT(S)/GUARDIAN(S) for Ages under 18

Name: _____ **Relationship to Child:** _____

Cell Phone: (_____)_____ **Work Phone:** (_____)_____

E-Mail: _____

ALL PERSONS AUTHORIZED TO PICK UP (If under the age of 18)

1. **Name:** _____ **Relationship to Child:** _____ **Phone:** _____
2. **Name:** _____ **Relationship to Child:** _____ **Phone:** _____
3. **Name:** _____ **Relationship to Child:** _____ **Phone:** _____

SIGNATURE: _____ **DATE:** _____

RELATIONSHIP TO APPLICANT (if under 18 years of age): _____

DONATION: $25 will be appreciated per applicant to offset expenses.

RELEASE AND AUTHORIZATION

Name: _____ Indicated in the space below are any health problems or conditions of which the instructor(s) should be aware (such as heart, back, medical, allergy, muscular, pregnancy, diabetes, epilepsy, chemical or neurological condition, special medication, knee/kidney/shoulder problems, etc.). I understand that risk of injury is inherent in any physical activity and I, on behalf of myself and my child, knowingly and voluntarily accept that risk. I, the undersigned, for myself, my heirs, administrators, and executors, hereby waive and release St Anthony Catholic Maronite Church, Lawrence, MA and its volunteers from any and all claims or damages of any kind arising out of my or my child's participation in the exercise and/or dance program. I further certify that the aforementioned is in proper physical condition to participate in the exercise/dance program and that he/she has been examined by a licensed physician and found to be in proper physical condition to participate in said program. I, the undersigned, do hereby authorize St Anthony Church or her designated agents (being teachers or volunteers) to obtain medical treatment for my said child in emergency situations where I cannot be reached in time to authorize the treating physician to provide such emergency medical services. I understand that I am responsible for any medical expenses and that the absence of health insurance does not make St Anthony Church responsible for payment of medical expenses. This authority includes the power to authorize any and all treatment deemed necessary under the circumstances by a licensed physician. This power is in essence a power of attorney and shall remain in effect for one year from the date signed below.

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____

WITNESS (Must be at least 18 years of age):_____

EMERGENCY INFORMATION

Physician: _____ Hospital Preference: _____

Insurance Company Policy No.: _____

Allergies (food, medicine, etc): _____

Additional Information/Comments:

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