School of Canadian Children's Dance Theatre

509 Parliament Street, Toronto, Ontario M4X 1P3 Tel [416] 924-5657 Fax [416] 924-4141 schoolofccdt@ccdt.org

Registration Form

Student Information

LAST NAME ____ FIRST NAME ____

ADDRESS ____ CITY ____ POSTAL CODE ____

BIRTHDAY (Day/Month/Year) ____ AGE (As of Oct. 1/03) ____ ALLERGIES/MEDS ____

NAME(S) OF GUARDIAN(S) RESIDING WITH STUDENT ____ HOME PHONE ____

EMAIL ADDRESS ____ CELL OR BUSINESS PHONE ____

NAME(S) OF GUARDIAN(S) NOT RESIDING WITH STUDENT ____ HOME PHONE ____

ADDRESS OF PARENT NOT RESIDING WITH STUDENT ____ CITY ____ POSTAL CODE ____

Release Form

NAME OF STUDENT ____

I hereby certify that my child is in good physical condition and is able to participate fully in this program. All current medical conditions requiring medication are outlined below. I release The School of CCDT and its teachers from liability in case of accident or injury. I understand that all classes will be conducted in the safest possible manner by trained professional instructors.

NAME OF PARENT/GUARDIAN ____

SIGNATURE OF PARENT/GUARDIAN ____ DATE ____

Class Information:

Technique	Level	Day(s)	Time(s)

Payment:

TOTAL: $ ____

☐ VISA: ____ EXP. (MM/ YY) ____/____

(Please note that service charges apply to VISA payments)

☐ CHEQUE $ ____