SKYPAC
SOUTHERN KENTUCKY
PERFORMING ARTS CENTER

Dance Fit Registration Form

Dates: Saturdays October 3rd – Dec 5th 10:00am- 11:00am

Payment/Refund Information:

Payments in full can be processed online. Monthly or by-class registration fees can be paid by cash or check (payable to *SKYPAC*). These can be mailed to **Attn: SKYPAC/Michelle Hale, PO Box 748, Bowling Green, KY 42102**, OR dropped off in person at SKYPAC.

No refunds will be given for cancellation. Missed classes are non-refundable.

Payment options: In Full $180.00/8 classes Monthly $95.00/4 classes Per Class $25.00/1 class

*[Additional] Bring-a-friend Discount: $15/1 class (with a completed single-class purchase)

TOTAL AMOUNT ENCLOSED: $_____

Participant Information - GENERAL INFORMATION

Name: _____ DOB: _____

Email: _____

Address:_____

Phone #1: _____ Phone #2: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relation: _____

Address:_____

Phone #1: _____

PARTICIPANT MEDICAL INFORMATION PLEASE INDICATE BELOW IF YOU HAVE ANY SPECIAL NEEDS OR REQUIREMENTS OF WHICH THE STAFF SHOULD BE AWARE: (ALLERGIES, MEDICATIONS, SPECIAL ASSISTANCE, ETC.):

_____

_____

HOW DID YOU HEAR ABOUT US? Check all that apply.

o WBKO/TV o SAM FM/Radio o Email o SKYPAC Website o A Friend Told Me About It o Other: _____

CONSENT and RELEASE Forms

I, _____, AGREE TO PARTICIPATE IN PROGRAMMING OF SOUTHERN KENTUCKY PERFORMING ARTS CORPORATION (SKYPAC). I UNDERSTAND AND AGREE THAT NEITHER SKYPAC, THE STAFF OF SKYPAC, NOR THE OWNERS OF THE PREMISES FOR EACH AND ALL PROGRAMS AND FUNCTIONS SHALL BE HELD RESPONSIBLE OR LIABLE IN ANY INJURY OR OCCURRENCE. I HEREBY RELEASE, HOLD HARMLESS AND FOREVER DISCHARGE THE ENTITIES LISTED IN THE PREVIOUS SENTENCE AND THEIR AGENTS FROM ANY AND ALL LIABILITY FOR ANY PERSONAL OR MEDICAL INJURY, CLAIMS INCURRED OR OCCURRENCE INCURRED WHILE OR ARISING AS A RESULT OF ATTENDING OR PARTICIPATING.

Signature: _____ Date: _____

IN CASE OF EMERGENCY, I GRANT MY PERMISSION TO RECEIVE MEDICAL TREATMENT AS DEEMED APPROPRIATE BY THE STAFF OR AGENTS OF SKYPAC ACCORDING TO THEIR BEST JUDGEMENT IF I AM UNABLE.

Signature _____ Date: _____

Photo Release Form

By signing below, I grant permission for SKYPAC to use photos from this program for any legal use, including but not limited to: publicity, copyright purposes, illustration, advertising, and web content.

Furthermore, I understand that no royalty, fee, or other compensation shall become payable to me by reason of such use.

Participant's Name: _____

Phone Number: _____

Date: _____

[optional] Dance Kids Registration Form

(in conjunction with Dance Fit only)

Payment Options: In Full - $75.00/8 classes Per Class - $10.00

TOTAL AMOUNT ENCLOSED: $_____

Participant Information - GENERAL INFORMATION

Student Name: _____ [Guardian approved] Preferred Name: _____

School: _____ Rising grade: _____ Age: _____

Parent/Guardian #1: _____ Email: _____

Address:_____

Phone #1: _____ Phone #2: _____

Parent/Guardian #2: _____ Email: _____

Address:_____

Phone #1: _____ Phone #2: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relation: _____

Address:_____

Phone #1: _____ Phone #2: _____

PARTICIPANT MEDICAL INFORMATION PLEASE INDICATE BELOW IF YOUR CHILD HAS ANY SPECIAL NEEDS OR REQUIREMENTS OF WHICH THE STAFF SHOULD BE AWARE: (ALLERGIES, MEDICATIONS, SPECIAL ASSISTANCE, ETC.):

_____

_____

CONSENT and RELEASE Forms

I DO HEREBY GRANT PERMISSION FOR _____ (NAME OF CHILD) TO PARTICIPATE IN PROGRAMMING OF SOUTHERN KENTUCKY PERFORMING ARTS CORPORATION (SKYPAC). I UNDERSTAND AND AGREE THAT NEITHER SKYPAC, THE STAFF OF SKYPAC, NOR THE OWNERS OF THE PREMISES FOR EACH AND ALL PROGRAMS AND FUNCTIONS SHALL BE HELD RESPONSIBLE OR LIABLE IN ANY INJURY OR OCCURRENCE REGARDING MY CHILD. I HEREBY RELEASE, HOLD HARMLESS AND FOREVER DISCHARGE THE ENTITIES LISTED IN THE PREVIOUS SENTENCE AND THEIR AGENTS FROM ANY AND ALL LIABILITY FOR ANY PERSONAL OR MEDICAL INJURY, CLAIMS INCURRED OR OCCURRENCE INCURRED WHILE OR ARISING AS A RESULT OF ATTENDING OR PARTICIPATING.

Signature of Parent/Guardian: _____ Date: _____

IN CASE OF EMERGENCY, I GRANT MY PERMISSION FOR MY CHILD TO RECEIVE MEDICAL TREATMENT AS DEEMED APPROPRIATE BY THE STAFF OR AGENTS OF SKYPAC ACCORDING TO THEIR BEST JUDGEMENT DURING MY ABSENCE OR IF I AM UNABLE TO BE CONTACTED.

Signature of Parent/Guardian: _____ Date: _____

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Furthermore, I understand that no royalty, fee, or other compensation shall become payable to me by reason of such use.

(if under 18 yrs. old) Parent/Guardian Signature: _____

Parent/Guardian Name: _____

(if 18 yrs. or older) Participant Signature: _____

Participant's Name: _____

Phone Number: _____

Date: _____