



Studio West Dance Center

ADULT CONTACT/EMERGENCY FORM

Class Participant Name: _____ Date of Birth: _____

Number of Years of Dance Experience _____ *no prior experience required, used for placement only

Address: _____

Phone Numbers: _____ home _____ wk _____ cell

Email Address: _____

I, _____, give permission for the following person(s) to be contacted in case of an emergency while I am at the Dance Center.

Primary Emergency Contact Information:

1. _____
Name(s) Address Zip

Home Phone Work Phone Cell Phone Email Address

Alternate Emergency Contact Information (optional, in case we cannot reach your primary contact above):

2. _____
Name(s) Home Phone Work Phone Cell Phone

Medical Information:

Physician's Name: _____ Phone: _____

Medications: _____

Health Concerns, Allergies, and/or Other Conditions that SWDC should be made aware of:

I hereby grant permission to Studio West Dance Center to authorize and obtain medical care from any licensed physician, emergency medical technician, hospital or medical clinic should I, the class participant, _____ (name), become ill or injured while under the Center's care. The Center will make every attempt to contact the emergency contact(s) above FIRST in the event of an emergency.

Adult Signature: _____ Date _____