



Turning Pointe Academy of Dance

Registration Form

Current Date: _____

Class(s) _____

Dancer Information

LAST NAME _____
FIRST NAME _____
BIRTH DATE _____

MIDDLE INITIAL _____
GRADE IN SCHOOL _____

Parent or Guardians (Address correspondence to & where you would like to receive E-mails)

LAST NAME _____
RELATIONSHIP _____
ADDRESS _____
CITY _____
HOME PHONE _____
CELL PHONE _____
HOME E-MAIL _____

FIRST NAME _____
STATE _____ ZIP _____
WORK PH. _____
WORK E-MAIL _____

LAST NAME _____
RELATIONSHIP _____
ADDRESS _____
CITY _____
HOME PHONE _____
CELL PHONE _____
HOME E-MAIL _____

FIRST NAME _____
STATE _____ ZIP _____
WORK PH. _____
WORK E-MAIL _____

Other Emergency Contact

LAST NAME _____
RELATIONSHIP _____
HOME PHONE _____
CELL PHONE _____

FIRST NAME _____
WORK PHONE _____

Medical Information

DOCTOR _____
DR. OFFICE PH. _____
ALLERGIES _____
MEDICAL PROBLEMS _____
MEDICATIONS _____

CLINIC _____
AFTER HOURS PH. _____