

Participants Information:

First Name:		Surname:	
D.O.B:		Ethnicity:	
Address:			
			Post Code:
Year Group:		School:	

Does the above named participant suffer from any medical or physical conditions that we should be informed of? (Such as asthma, panic attacks, epilepsy, diabetes, ADHD, SEND etc) Please provide details below. If none, please write 'None'.

Is it necessary for the above named participant to take any medication (such as inhalers) whilst attending our sessions? Please provide details below or write 'None' if there are none.

Does the above named participant suffer from any allergies? Please provide details below or write in 'None' if there are none.

Emergency Contact:

First Name:		Surname:	
Address:			
			Post Code:
Tel:		E-Mail:	
Relationship to child:			

(Please note in the event of an emergency it will be the person above who will be the first point of contact)

Terms & Conditions of your membership:

We ask that as part of your membership you hereby give Yorkshire Academy of Creative Arts and Dance permission to use any still and/or moving image being video footage, photographs and/or frames and/or audio footage for any of the following uses: Advertisements, marketing, leaflets, or any other use such as for training, educational or publicity purposes.

You give Yorkshire Academy of Creative Arts and Dance practitioner's permission to use physical touch to enhance the learning of participants.

You give Yorkshire Academy of Creative Arts & Dance permission to share your details with funders if your child is in receipt of any funded places with us.

Any fees owed must be paid in a timely manner, The parent/guardian are liable for covering any fees that are incurred by any external agencies due to non-payment of outstanding debts.

Childs Name:	
Parent/Guardian Name:	Parent/Guardian Signature:

Declaration:

By signing this form, you confirm that the above-named participant is physically, mentally, and medically fit to participate our sessions. If you are in any doubt, please consult the child's medical practitioner before starting sessions.

Parent/Guardian Name:	Parent/Guardian Signature:
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Office use only

Received By (initial):		Method of Payment:		Date Paid:	
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(Please Tick)

PP:		FSM:		SEND:	
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Received School Confirmation

Data Upload

Eligible for funded activities

OFFICE STAMP
