



1 Center Dr.
Belgrade, ME. 04917
Tel: 495-3481 Fax: 495-3481
email: communitycenter@belgrademaine.com
VISIT OUR WEBSITE: www.belgrademaine.com

3:30-4:30PM
THURSDAYS
INTRODUCTION TO DANCE

\$9/CLASS

JUNE RECIDAL SCHEDULED

Family Physician Name: _____

Physician Phone #: _____

Any Allergies or Dietary Considerations? _____

Any Medical Problems (include past injuries) _____

DANCE Registration Form

PLEASE MAKE CHECKS PAYABLE TO: **YOUNG AMERICANS SCHOOL OF DANCE** (PAY THE INSTRUCTORS)
AND RETURN YOUR REGISTRATION FORM TO: BELGRADE COMMUNITY CENTER, 1 CENTER DR. BELGRADE, MAINE. 04917

Participants Name (First Name, Last Name)	Gender	Grade	D.O.B.	Age	3:30-4:30	Program Fee
						\$9/CLASS
					Balance Due	

CLASSES BEGIN SEPTEMBER 15. PLEASE CALL MS. MAUREEN AT 547-3812, IF YOU HAVE QUESTIONS.

PAY BY THE MONTH OR DAY YOU ONLY NEED TO REGISTER ONCE.

Email Address: _____

Mailing Address: _____ Home Phone: _____

Mother's Name: _____ Work Phone #: _____

Father's Name: _____ Work Phone #: _____

Should we be unable to contact you in the event of an emergency, please list the name and contact number of another responsible adult we may be able to reach.

Emergency Contact: _____ Day Phone: _____ Night Phone: _____

Participation in this activity may involve risk of injury or death. As a parent, guardian, or participant I am aware of these hazards and my/(my child's) ability to participate. In registering for participation in the programs(s) listed above, I hereby waive and release all rights and claims against the Town of Belgrade and the Waterville Boys and Girls Club and YMCA, its officers, employees, agents, volunteers and supervisors from all losses, injury, damages, fees and other expenses arising out of, or in connection with participation in the above registered activity. In addition, I give my consent for the Belgrade Community Center and staff to act in my place in all respects should the need arise during the course of this activity or related travel. This shall include but not be limited to obtaining medical care.

Parent/Guardian Signature: _____ Date: _____

FOR OFFICE USE ONLY

PAID: _____

CH.CK#: _____

DATE: _____