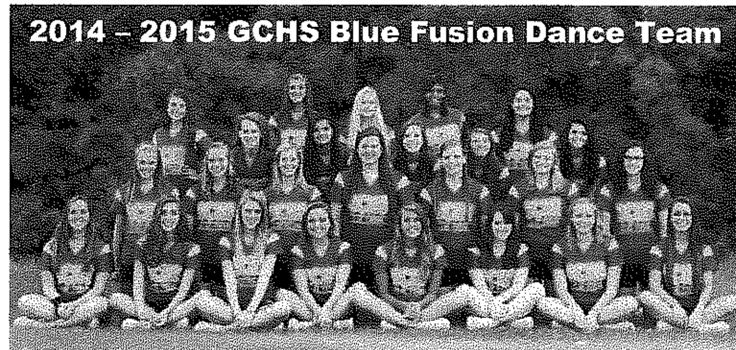
Greenfield Central High School Blue Fusion Dance Team

Dance Clinic – Grades K – 6

Hosted by Blue Fusion Dancers

WHEN: Saturday, November 1, 2014, 9:30AM – 3PM (Registration: 8:45AM)
WHERE: Greenfield Central Junior High School
COST: $25 (non-refundable)
INCLUDES: Cool T-Shirt, Lunch*, performance by GCHS Blue Fusion



- Clinic will be led by members of the GCHS Blue Fusion Dance Team with coach supervision!
- Learn proper motions and technique to a hip dance routine!
- Fun time with others who like or want to learn dance!
- Chance to meet new people and make new friends!

~ Performance by dance clinic participants for parents/family will begin at 2:30PM ~

(tear off registration/return with payment)

*****COMPLETE BOTH SIDES*****

REGISTRATION

Complete both sides of form and return to: GCHS Dance, ATTN: Brittany Nigh, 810 North Broadway St., Greenfield, IN 46140. Include your registration fee of $25. Checks should be written to *GCHS Dance Team* with memo to Dance Clinic. **DUE DATE: October 3, 2014.**

Name of Dancer: ______________________________

Age: ______ Grade: _______ School: ______________________

Address: ______________________________

Parent Name: ______________________ Phone #: __________

Emergency Contact Name and Phone #: ______________________

Shirt Size: **YOUTH** : S M L –or– **ADULT**: S M L XL (*circle one*)

* Lunch will be: Hot Dog, Chips & a Bottled Water. If your child will be bringing his/her own lunch due to allergies, please check here: ☐ **PLEASE NOTE**: refrigeration not available.

*****COMPLETE BOTH SIDES*****

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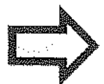
Thank you for allowing us this time with your child(ren)!!

(tear off registration/return with payment)

*****COMPLETE BOTH SIDES*****



I will not hold Greenfield-Central Community School Corporation or the Greenfield Central High School Blue Fusion Dance Team liable for any injuries occurring at the Blue Fusion Dance Clinic on November 1, 2014. I hereby give my consent for my child to participate in the Greenfield Central High School Blue Fusion Dance Team Clinic. I also give my consent for emergency medical and surgical treatment of this minor in a licensed hospital by a licensed Indiana physician should their condition require it in my absence.

Parent or Guardian Signature: ______________________ Date: ____________

Family Doctor: ______________________ Phone: ____________

Medical Insurance: ______________________ Policy#: ____________

Please List Any Medical Information Which You Feel Should Be Known: ______________________

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*****COMPLETE BOTH SIDES*****