REGISTRATION AND RELEASE FORM

FALL 2010 SESSION
SEP 7, 2010 – MAY 28, 2011

490 E. IL Route 22
Lake Zurich, IL 60047
Phone 847-438-6424
Fax 847-726-0491
www.TrilogyDance.com

Student Name	**Date of Birth**	**Class Name** (schedule)	**Instructor** (schedule)	**Day/Time** (schedule)	**Price** (schedule)
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Parent/Guardian Name (if under 18)_____ **Sub Total** _____

Address_____ City_____ Zip_____ **Less Discount** (trilogy facts) _____

E-mail_____ **Registration** (trilogy facts) _____

Cell Ph_____ Home Ph_____ Work Ph_____ **TOTAL** _____

Payment Method: ☐ **Credit Card** **Card Type**_____ ☐ **Check** **Check#**_____

Credit Card #_____ Security Code_____ Name on Card_____ Exp Date____/___

I give Trilogy School of Performing Arts permission to charge my credit card_____
Signature

Special Allergies, Chronic Illness, or other medical conditions of student:_____

THE UNDERSIGNED AGREES THAT:
I hereby agree to release, and indemnify Trilogy School of Performing Arts, its agents, and employees (hereinafter Trilogy School of Performing Arts) from any and all liability (including attorney's fees) arising from, because of, or in connection with personal injury, illness, property damage, or property theft occurring on or off the schools premises. I have read the registration information as outlined in "Trilogy Facts" document and I understand the School's policies. I understand that I am responsible for tuition payments as described in "Trilogy Facts". I certify that I am in good health and capable to participate in all school activities and classes. I hereby give permission for Trilogy School of Performing Arts to take videos and photographs for promotional uses for the school. I understand that Trilogy School of Performing Arts is using electronic devices to monitor its facilities.

Student Signature_____ **Parent/Legal Guardian Signature**_____ Date_____

My signatures above and below affirm the fact that I have completely read, understood and agreed to all the terms and conditions of this Agreement.
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Medical Emergency Authorization (if under 18)
To Whom it May Concern: As parent/legal guardian, I authorize the treatment by a qualified and licensed medical doctor of the above named minor in the event of a medical emergency which, in the opinion of the attending physician, may endanger the minor's life, cause disfigurement, physical impairment or extreme discomfort, if delayed. This authority is granted only after a reasonable effort has been made to contact me. This release is effective from date of signing until the end of the session as listed on this form.
This release is completed and signed of my own free will with the sole purpose of authorizing medical treatment.

Signature of Parent/Legal Guardian_____ Date_____

FOR OFFICE USE ONLY:

Date_____ Receipt# _____Check # _____ Total Paid_____ Balance Due_____