



REGISTRATION AND RELEASE FORM

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

**SUMMER 2010 SESSION
JUNE 8 – AUGUST 31, 2010**

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 _____					_____
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.

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 _____