

Lexington School of Ballet, Inc.
 1403 Massachusetts Avenue | Lexington, MA 02420 | 781-861-9349
2018-19 Registration Form

student _____

date of birth _____ / _____ / _____ school grade (Sept 2018) _____

prior training (new students only) _____

address _____

city _____ state _____ zip _____

parent #1 (primary contact): _____

phone _____ e-mail _____

parent #2 _____

phone _____ e-mail _____

Class Name	Day(s)	Time(s)	Hours/Week
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Total Hours/Week			_____
Tuition			\$ _____
*Munroe Center Fee			\$ _____
Total Due			\$ _____

Tuition rates are based on total number of hours per week, combined for all family members.
 *Mandatory Munroe Center for the Arts Building Fee is \$35.00 per student or \$75.00 per family of 3 or more students.

DISCLAIMER
I understand that the Lexington School of Ballet, Inc. is accepting me, or my child, as a student. I realize that there are certain dangers possible in the art of dancing. I agree to assume the risk of all injuries or damage that may arise from my, or my child's participation in dance activities at the Lexington School of Ballet, Inc. I certify that I, or my child, is in proper physical condition to take part in dance activities. In consideration of the above, I hereby release and hold harmless the Lexington School of Ballet, Inc. and their teachers, directors, pianists and agents from and against any liability or claim for any injury, misadventure, harm, loss, cost or damage sustained as a result of my, or my child's, participation in the Lexington School of Ballet, Inc. classes and activities. I have read this release and understand its meaning.

Signature _____ Date _____

_____ Please initial if you authorize LSB to use photos of your child for newspaper articles, performance posters or program brochures.

MEDICAL EMERGENCY & HEALTH INFORMATION

I authorize the Lexington School of Ballet to consent to emergency medical treatment for my child.

Health Insurance Company _____ Member ID# _____

OR

I do not authorize the Lexington School of Ballet to consent to medical treatment for my child and therefore agree that I or my representative will remain outside the classroom during my child's class.

Signature _____ Date _____

Health concerns LSB should be aware of: _____

For office use only.

Munroe Fee	\$ _____	Date: _____	Term _____	<input type="checkbox"/> Cash	<input type="checkbox"/> Check # _____	<input type="checkbox"/> FM	
Tuition	\$ _____	Date: _____	Term _____	<input type="checkbox"/> Cash	<input type="checkbox"/> Check # _____	<input type="checkbox"/> FM	<input type="checkbox"/> Class List
Tuition	\$ _____	Date: _____	Term _____	<input type="checkbox"/> Cash	<input type="checkbox"/> Check # _____	<input type="checkbox"/> FM	<input type="checkbox"/> Class List