

The Scottsville Center for Arts and Nature
401 Valley Street (Victory Hall Theatre)
P.O. Box 725, Scottsville, VA 24590
434-286-2806
www.scottsvillecenter.org

REGISTRATION FORM (mail to above address)

Student Name: _____

Age: _____ DOB: _____ Years of Training: _____

Class/Workshop: _____

Parent(s) Name (print clearly) _____

Address _____ City _____ Zip _____

Home Phone _____ Cell _____ Office _____

Email _____ (No email, check here) _____

Parent Signature _____ Date _____

Medical Information/History

This information enables us to deal effectively and responsibly with our students.

ALL informatio provided is confidential.

1. Does your child have any of the following conditions:

Heart problems ___ Asthma ___ Allergies ___ Seizures ___ Hypoglycemia ___ Other? _____
Allergic to: _____

2. Is your child on any regular medication that may affect his/her performance?

Yes ___ No ___

If yes, please explain _____

3. Does your child have any physical problems in the following areas?

Knees ___ Back ___ Hips ___ Feet/Ankles ___ Neck ___ Other? _____

4. Is there any other area we should know about that may affect your child's performance in any class/workshop?

Yes ___ No ___

If yes, please explain _____

Emergency Contacts"

Name: _____ Phone: _____ Relation _____

Name: _____ Phone: _____ Relation _____

OFFICE USE ONLY:

Date Received: _____ Database entry: _____ Initial: _____

Payment Type:

Check: _____ Cash: _____ Money Order: _____