Greenfield Central High School Blue Fusion Dance Team

Dance Clinic – Grades K – 6

Hosted by: **2016 & 2017 State Champ Blue Fusion Dancers!!**

WHEN: Saturday, November 10, 2018
TIME: 8:30 – Registration; 9:00AM – Start; 11:45AM Performance for Parents
WHERE: Greenfield Central Junior High School
COST: $25 (non-refundable) –
**** Includes Cool T-Shirt, Snack

- Clinic will be led by members of the **Indiana State Champion 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 will begin at 11:45AM ~

(tear off registration/return with payment)

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

REGISTRATION

Complete both sides of form and return to: GCHS Dance, ATTN: Brittany Taing, 810 North Broadway St., Greenfield, IN 46140. Include your registration fee of $25. Checks should be payable to: *GCHS Dance Team,* with memo to: *Dance Clinic*. **DUE DATE: October 20, 2018.**

Name of Dancer: _____

Age: _____ Grade: _____ School: _____

Parent Name: _____ Phone #: _____

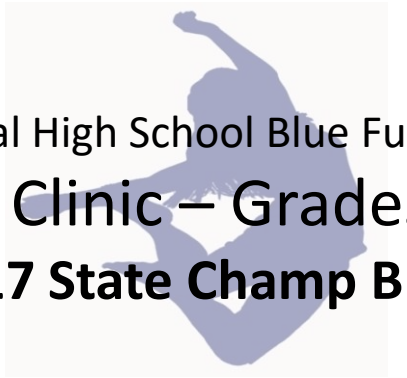
E-mail Address (for reminders): _____

Emergency Contact Name and Phone #: _____

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

* Snack will be: Goldfish & a Bottled Water. If your child will be bringing his/her own snack 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 10, 2018. 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: _____

_____

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