Greenfield Central High School
Blue Fusion Dance Team
Grades K - 6th Dance Clinic

Hosted by : 2nd place State Champions Blue Fusion Dancers

When: Saturday September 17th

Time: 1:30 p.m. Registration; 2:00 p.m. Start; 5:00 p.m Parent Performance

Where: Greenfield Central High School Main Gym (Door 33)

Cost: $45.00 (non-refundable)

Includes: Snack & T-shirt **(Deadline to receive T-shirt, Tuesday September 6th)**

Questions?? Email: eads1208@comcast.net

- Clinic will be led by members of the GCHC Blue Fusion Dance Team with coach supervision.
- Learn proper motions & technique to a cool dance routine!
- Fun time with others who like or want to learn to dance!
- Chance to meet new people and make new friends.

Home Football Game Performance scheduled for Friday September 30th: Pregame & After 1st Quarter. Please drop your dancer off no later than 6:15 p.m. and pick them up after the 1st quarter performance. Location to meet for drop off and pick up, South end of the football field at the Fieldhouse parking lot gate. Dancers will get into the game for free but parents will need to purchase a ticket. Please wear your clinic T-shirt to the game.

Thank you for allowing us this time with your child(ren)!!

Complete Registration form and return to GCHC Dance, ATTN: Jennifer Johnston, 810 N. Broadway St., Greenfield, IN 46140. Include your registration fee of $45.00. Make checks payable to: GCHS Dance Team, with memo to Dance clinic.

Name of Dancer: _____

Age:_____ Grade: _____ School: _____

Parents Name: _____

E-mail address (for reminders):_____

Emergency Contact Name & Phone #:_____

Shirt Size: Youth: S M L –or– Adult: S M L XL
(Circle One)

I will not hold GCSC or the GCHS Blue Fusion Dance team liable for any injuries occurring at the Blue Fusion Dance Clinic on September 17, 2022. I hereby give my consent for my child to participate in the GCHS 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 our absence.

Parent or GuardianSignature: _____ Date: ____

Family Doctor:_____ Phone:_____

Medical Insurance:_____ Policy#:_____

Please list any medical information which you feel should be known (food allergies): _____