Standing Ovation Talent Group

9401 West Colonial Dr., Suite 226, Ocoee, FL 34761
(Inside the West Oaks Mall)
www.standingovationtalentgroup.org

REGISTRATION FORM

Student:_____Date of Birth:_____/_____/_____ Age: _____

Parent (1): Mr./Mrs./Ms._____

Parent (2): Mr./Mrs.Ms._____

Address:_____Home Phone:_____

City_____State_____Zip_____Cell Phone:_____

Email:_____

Any medical concerns: Yes_____No_____ If yes, explain:_____

Emergency Contact:_____Relationship to Dancer_____

Phone (1):_____ Phone (2):_____

Parent and Student Agreement to Rules, Regulations, and Terms of Insurance

(Rules, Regulations and Terms provided in registration packet)

_____	_____	_____
Parent/Guardian Name (PRINT)	***Parent/Guardian Signature***	***Date Signed***
_____	_____	_____
Student's Name (PRINT)	***Student's Signature***	***Date Signed***

Referred to SOTG by: _____

Please provide questions or comments below:

_____

_____

EMERGENCY MEDICAL INFORMATION FORM

Dancer's Full Name:_____

Address: _____

City: _____

Home Phone: (_____)_____ Age: _____ Date of Birth:____/____/____ Grade: ____

Doctor's Name: _____

Doctor's Address: _____

Doctor's City: _____ Doctor's State: _____ Doctor's Zip: _____

Doctor's Phone: _____

Insurance Co: _____ Insurance Policy #: _____

Mother's Contact #: (_____)_____ Father's Contact #: (_____)_____

Emergency Phone #: (_____)_____ Name of Relative: _____

Emergency Phone #: (_____)_____ Name of Relative: _____

AUTHORIZATION TO TREAT

In the event of a serious accident or illness and I cannot be reached, I hereby authorize Standing Ovation Talent Group (SOTG) to contact the physician or dentist and for those professionals to provide protected health information.

In the event of an EMERGENCY, I understand that SOTG will access the **911** emergency medical system immediately. To expedite care, I give my permission for SOTG personnel to provide medical information to the responding emergency team to initiate treatment, and transport to an appropriate facility. I give my permission for the appropriate medical personnel and staff to initiate treatment immediately upon arrival to the appropriate facility. I request to be notified of my child's condition and admission as soon as possible. If I cannot be reached I request that the admitting facility notify one of the other persons listed above of my child's condition and admission. I agree to be financially responsible for my child's total treatment, and transport.

I have reviewed the above information and have made corrections as needed.

Permission to: ☐ Call Doctor ☐ Call Ambulance ☐ Treat