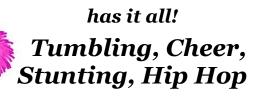
Camp Cheertastic





Studio of Dance
(610) 494-4610

www.paulklockedance.com
300 Turner Industrial Way, Aston, PA 19014

Rah Rah Sis Boom Ba! Join us for Tumbling, Cheerleading, Stunting, and Hip Hop. No specific skill level is required, only a desire to learn!

- Ages 6-11
- June 27- July 1 (Mon. thru Fri.)
- Time: 1:00p-4:00p
- Show and Awards (Fri. 3:15p)

*Enroll in Doll Camp for a special combo rate. Pack your lunch and spend the whole day with us.

Registration Form

Student's First Name	Last Name		Age	Birthda	te	
Health Concerns the studio should	know about?					
Food/Other Allergies the studio sho	uld know about?					
If the information below is alr sure), fill in only the field	ready correctly on file with us ls that need to be updated.	s, check the bo	x to the left. If your in	nformation h	as changed (or you are not
Mother's First/Last	Fat	her's First/Last				
Street Address	Email Address					
City		Sta	ate2	<u>Z</u> ip		
Home Phone Number	Emergency	Name & Numb	er			
Mother's Cell Number		_ Father's Cell	Number			
Mother's Work Number		_ Father's Wor	k Number			
How did you find out about our stud	lio?		Year	s you have	studied?	
Camp Cheertastic	Amt. if Enrolled by 3/24/	16 A	mt. if Enrolled by 5/22/	16	Amt. if Enrolled	d after 5/22/16
1:00p - 4:00p (5-day) MonFri.	\$159		\$173		\$188	3
Add Doll Camp (9:30-12:00)	Add \$113		Add \$121		Add \$1	32
Photo Release: I accept that the sture used in studio displays and social med Form" that must be signed by both a parameter ("PKSD"), and any of its affiliated Dance ("PKSD"), and any of its affiliated Recognizing the possibility of physical in hereby release, discharge, indemnify, and against any and all claims by or on PKSD, through its staff, to obtain emer of my child due to accident or illness. I presentation of the bill to me. Signed (parent/guardian) Amount Enclosed	ia promotional materials. If I do arent (and/or Guardian) and the lian of the above named registra I organizations. I consent to the proof of hold harmless the PKSD, its abehalf of the registrant as a resu gency medical care in the even promise to pay any treatment of	not want picture studio Director. Int agree that the registrant's partic RAMS, and in cor affiliated organiza alt of the registran at that such care costs directly to t	s taken, I will obtain an registrant and I will abid pation in the PKSD phy isideration for the PKSE tions, and their employed it's participation in the Plis necessary or approphe hospital, physician,	le by the rules sical program of accepting the ees, teachers ROGRAMS. I riate in the operation of laboratory	s of the Paul Klons and activities are registrant for and associate In my absence, pinion of the st	o's "No Photo ocke Studio of s, ("PROGRAMS") its PROGRAMS, d personnel from , I also request aff for the benefit n care, upon
Make Checks Payable to: Paul I	For Office Use					
(Mastercard/Visa/Check/Cash accepted)		Check		dit Card	Billed	Payment

Number

Cancellation/Refund Policy: If notified 28 days before first day of Camp - 80% refund given; if notified 14 days before first day of Camp - 50% refund given; 0-13 days before first day of camp - no refunds can be given.

Receipt #

Last 4 digits

Fox

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