



## Mazomanie Movement Arts Center Class/Workshop Registration Form

So glad you are going to join us for a class or workshop!  
Please print this form, fill it out completely, and send it, along  
with your payment, to: The Mazomanie Movement Arts  
Center; PO Box 471; Mazomanie, WI 53560.

**Class Name, Date(s), Time:** \_\_\_\_\_

**Participants Name, Age:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

**Phone Number(s):** \_\_\_\_\_

**E-mail:** \_\_\_\_\_

May we use photo/video of you/your child for future promotions? \_\_\_\_\_

May we share your contact info with other parents or class participants for car-pooling purposes? \_\_\_\_\_

### **Release of Liability:**

I hereby release the Mazomanie Movement Arts Center, its members, agents and volunteers of all liability. By signing this release, I understand that I am absolving and releasing others from liability from their own negligent acts, even if I am not at fault in any way. In consideration of my/my child's participation in classes or other activities at or associated with the Mazomanie Movement Arts Center, I agree to assume full responsibility for them, their heirs, executors, and administrators, waive and release and forever discharge any and all rights and claims for damages which they may have or which occur to them, for all damages which may be sustained and suffered by them in connection with their association with or entry into center activities or which may arise out of their participation in these activities. I expressly assume all of the risks inherent in these activities

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

### **Emergency medical/contact information:**

Do you have limiting disabilities (temporary or permanent?) yes \_\_\_\_\_ no \_\_\_\_\_

If yes, explain: \_\_\_\_\_

Are you currently under a physician's care or taking medication for any condition? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, explain: \_\_\_\_\_

Have you had any previous injuries (aside from minor scrapes/bruises)? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, explain: \_\_\_\_\_

Do you have any allergies? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, list: \_\_\_\_\_

**Emergency contact name(s) and telephone(s):** \_\_\_\_\_

\_\_\_\_\_