

Movement Arts Collective

1708 Washington Ave.
Seaford, NY 11783
516-544-6255

Participant Name:_____ Birthday:_____

Emergency Contact Information:

Name:_____ Relationship:_____

Preferred Phone Number:_____ Email Address:_____

Please list any medications the participant are taking:

Does the participant have any allergies? (if so, please list them below)

Please list any injuries, limitations, or disabilities that our staff should know about so we can provide the safest and most appropriate environment we can during class!

Disclaimer- this information is confidential and will only be shared with medical professionals if necessary to ensure safety

Photo Release Form

Movement Arts Collective

Participant name: _____

By signing this form, I am giving permission to Movement Arts Collective to use class or performance photographs and videos for marketing and advertising purposes.

X_____

Date:_____