

SAINT LOUIS BALLET

GEN HORIUCHI, ARTISTIC DIRECTOR

Registration Form: Summer Programs

Current student of St. Louis Ballet School

Name of Student _____

Birthdate and Age _____

PLEASE CHOOSE WHICH PROGRAM

SLEEPING BEAUTY PRINCESS CAMP

3-4 Year Old (before May 1)

5-6 Year Old (before May 1)

T-Shirt Size _____

(If before June 1st)

SUMMER BALLET PROGRAM

Circle Weeks Desired

Levels 2-3

Wk 1 Wk 2 Wk 3

Intermediate (Levels 4-6)

Wk 1 Wk 2 Wk 3 Wk 4

Advanced (Levels 7-8)

Wk 1 Wk 2 Wk 3 Wk 4

Name of Parent/Guardian _____

Address _____

City, State, Zip _____

Phone numbers (include cell phone also for emergency) _____

Email _____

Name(s) of Additional Student(s) in SAME program

Sibling Discounts are applied if registered in same summer program

TUITION FOR PROGRAMS

SLEEPING BEAUTY FAIRY CAMP

\$135 + \$15

SUMMER BALLET PROGRAM

Levels 2-3 \$95 per week

6 classes/wk

Intermediate (Levels 4-6)

\$225

16 classes/wk

Advanced (Levels 7-8) \$225

16 classes/wk

HOST FAMILY OPTION \$350/wk

I will need housing through the Host Family Program.

As a parent, I am interested in being a chaperone for a visiting student.

TUITION TOTAL

First Child Program Total _____

Second Child

(20% Discount if Same Program) _____

Registration Fee:

\$15 per family

Subtotal: _____

Deposit Due:

- \$50 (non-refundable)

Balance Due: _____

Parent/Guardian Signature _____

Date _____

* Once a student begins the program there will be no refunds on tuition for any reason as their position has already been held prior and can no longer be filled once the program has started.

SUMMER PROGRAM MEDICAL FORM TO BE COMPLETED

Student's Medical Information

Student's Name _____

Student must have had a physical exam within the last 6 months.

Are the student's immunizations current? Yes No (Circle)

Parent's Signature:

Any medical condition(s) and/or allergies

Is student on medication for this condition(s) and/or allergies?

Are there any special needs for this condition(s) and/or allergies?

Medical Insurance Information

Student must have medical insurance.

PLEASE ATTACH A COPY OF YOUR INSURANCE CARD

Medical treatment is the responsibility of parents/guardians.

Insurance Company _____ Policy Number _____

Insurance Co. Address _____

Name on Policy _____

Name of Company (employer) _____

Policy Holder's Social Security Number _____

Student's Social Security Number _____

Policy Holder's Relationship to Student _____