

**A.C.T. 2024/25 REGISTRATION FORM**  
**(SHANDON WEEKDAY SCHOOL)**

1<sup>st</sup> Child's Name (last) \_\_\_\_\_ (first) \_\_\_\_\_

Age as of August 1<sup>st</sup> \_\_\_\_\_ Birth date \_\_\_\_\_ School \_\_\_\_\_

2<sup>nd</sup> Child's Name (last) \_\_\_\_\_ (first) \_\_\_\_\_

Age as of August 1<sup>st</sup> \_\_\_\_\_ Birth date \_\_\_\_\_ School \_\_\_\_\_

Parent's Name \_\_\_\_\_ E-mail address \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Home phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Emergency Contact Name \_\_\_\_\_

Emergency Phone Number if we can't contact parent \_\_\_\_\_

Physician's Name \_\_\_\_\_ Physician's phone \_\_\_\_\_

Insurance carrier \_\_\_\_\_ Policy Number \_\_\_\_\_

**Authorization and Release**

Please initial:

\_\_\_\_\_ I hereby release Action Cheer & Tumble, it's staff, and the owner of any class facilitator, from illness related to the coronavirus.

\_\_\_\_\_ I understand that monthly tuition is \$70 and is due the first lesson of each month. Registration fee is \$40 per child and must be pad one time per school year.

\_\_\_\_\_ I understand that I must pay a \$5.00 fee for tuition not received on or before the first lesson of each month.

\_\_\_\_\_ I understand that I must give 2 weeks notice if I decide to drop the class or I am responsible for the next month's tuition.

\_\_\_\_\_ I understand that a \$20 fee will be accessed for all returned checks.

\_\_\_\_\_ I understand that tuition will not be adjusted for short or long months, nor for missed classes.

\_\_\_\_\_ I am fully aware that any activity involving motion or height such as those involved in cheerleading/tumbling creates the possibility of serious injury and I further agree to hold Pam Boggs, Instruction Marketing Services Inc., (dba Action Cheer and Tumble), and her staff harmless for any injury or any resulting expense. I release and discharge any and all claims against Pam Boggs, Instruction Marketing Services, Inc. (dba A.C.T.), and all affiliated parties.

\_\_\_\_\_ I authorize Pam Boggs or her staff to seek medical treatment for my child when I cannot be reached.

Allergies or conditions or concern \_\_\_\_\_

Parent's signature \_\_\_\_\_ Date \_\_\_\_\_