STUDENT REGISTRATION FORM

Student's Name				Birthdate
Current Diagnosis	Treating Therapist/Teacher that we will work with			
Treating Clinic/School			Treating Clinic/School Phone	
Treating Clinic/School Address				
City	State			Zip
Guardian 1 Name				Relationship to Student
Guardian 1 Mailing Address (Street or PO)				
City	State			Zip
Guardian 1 Cell Phone	Guardian 1 Email Address			
Guardian 2 Name				Relationship to Student
Guardian 2 Mailing Address (Street or PO)				
City	State			Zip
Guardian 2 Cell Phone	Guardian 2 Email Address			
Please let us know anything that will help our staff provide the best possible learning experience for your student (sensitivities, developmental goals, behaviors, what helps self-regulation...)				

Credit Card (Visa/MC only)	Exp. Date	CVV	Billing Zip	Amount
Name on Credit Card	Signature			

Return to: tricia@danceinabox.com or fax to 310-793-2623