Millikan High School's
Advanced Dance Team’s
DANCE CLINIC

PLEASE RESERVE MY/OUR SPOT.
I/WE WOULD LIKE TO PARTICIPATE IN THE DANCE CLINIC

Dancer(s) Name(s): __________________________________ Age(s): __________
Phone Number: ________________________________
School I Attend: ______________________________
Referred By: _________________________________
T-Shirt Size {\text{(Y)outh - S, M, L, XL} or \text{(A)dult - S, M, L, XL}}: _________
(Youth T-Shirt Sizes: S=6-8, M=10-12, L=14-16)
$35.00 x _____________ Dancer(s) = $ ______________ *

*Cash or Check payable to MAD Boosters
(any returned check is subject to a $33.00 Returned Check Fee)

Return this form to:
MAD Boosters c/o Danette Hudkins 4874 E. Los Coyotes Diagonal, Unit #2, Long Beach, CA 90815
Contact Mrs. Waters - MHS Dance Advisor @(562)425-7441 ext. 4474 jwaters@lbschools.net
OR Danette Hudkins @(562)688-3570 eventsplanit@gmail.com with any questions.

I understand and acknowledge that as provided in part of Education Code 35330, I waive and forever release and discharge the Long Beach Unified School District, the Board of Education and it's officers, employees and agents from all liability, claims, loss, cost or expense arising from or attributable to the above identified activity. To the best of my knowledge, my child has no physical condition, which would interfere with his/her ability to participate in or attend this activity or would endanger his/her health or any other student's health.

___________________________________
Signature of Parent/Guardian Date

MEDICAL AUTHORIZATION

Should my child need to have medical treatment while participating in this activity, I hereby give the school district personnel permission to use their judgment in obtaining medical service for my child and I give permission to the physician selected by the school district personnel to render medical treatment deemed necessary and appropriate by the physician. I understand that the school district has no insurance covering such medical or hospital costs incurred for my child and, therefore, any costs incurred for such treatment shall be my sole responsibility.

___________________________________
Student's Name

Emergency Telephone Number

Home Address Zip Code

Home or Cell Phone Number

E-Mail Address

___________________________________
Signature of Parent/Guardian Date