


Victorian State Ballet
Summer Dance Intensive Enrolment Form

Surname: _____ Given Name/s: _____

D. O. B _____ / _____ / _____ Age: _____ Male Female

Address: _____
_____ Post Code: _____

Phone: _____ Mobile: _____

Names of Parents/Guardian (1) _____ (2)

Emergency Contact Number: (1) _____ (2)

Would you like to be notified via email about news, rehearsals and upcoming productions at VSB?

Yes No Email: (if Yes, please print) _____

Payment EFT to Victorian State Ballet only \$420

Via EFT - BSB: 083-004 Account Number: 761849252 Account Name: Victorian State Ballet Academy

Medical Details: Are there any medical conditions affecting you/your child which we should be aware of?

Please state: _____

Doctors Name: _____ Phone: _____

Dance Educational Background: Previous Dance School: _____

Method: _____ Level Achieved: _____

Number of Years learning: _____ Number of Classes per week: _____

Conditions of Enrolment

Please read carefully

1. Enrollment forms of students under 18 years of age must be signed by a parent/guardian.
2. Full payment of fees must be paid prior to commencement of the summer program. No refund of fees will be given under any circumstances once the program has commenced. All students must be suitably groomed according to each style and genre of class in the program. Students will not be able to participate in class without suitable attire.
3. Parents and friends will not be allowed to view summer classes except the final display or unless permission has been given by the Director.

VSB Marketing Authority (please tick the appropriate box)

I, the undersigned give permission for my/my child/children's photograph to be taken during classes at the summer dance week for the purpose of use of images in any advertising which may include website, prospectus, brochures, magazine, social media, display and other marketing materials or displays at VSB's discretion Yes No

I have read and understand the Conditions of Enrolment, and agree to comply with all the conditions. In the event of illness or accident, where I cannot be contacted, I authorize the staff of VSB to refer my child to a doctor or hospital.

Signed: (parent/guardian/student over 18) _____ **Date:** _____/_____/_____