DragonFly®

Artistic Director: Merrilee Hodgins ARAD
Programme Director: Barbara Roblin, OTC

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PLEASE PRINT

STUDENT LAST NAME:_____STUDENT FIRST NAME:_____

ADDRESS:_____

CITY:_____PROVINCE:_____POSTAL CODE:_____

DATE OF BIRTH(m/d/y):_____HOME TELEPHONE #:_____

NAME OF ACADEMIC SCHOOL:_____PRESENT LEVEL:_____

E-MAIL:_____

PARENT/GUARDIAN:_____RELATIONSHIP:_____

HOME TELEPHONE #:_____CELL PHONE #:_____

PLACE OF BUSINESS:_____BUSINESS TELEPHONE #:_____EXT:_____

PARENT/GUARDIAN:_____RELATIONSHIP:_____

HOME TELEPHONE #:_____CELL PHONE #:_____

PLACE OF BUSINESS:_____BUSINESS TELEPHONE #:_____EXT:_____

EMERGENCY CONTACT:_____RELATIONSHIP:_____TELEPHONE #:_____

Health Information:
DOCTOR'S NAME:_____ DOCTOR'S TELEPHONE #:_____ BLOOD TYPE: _____

OHIP/RAMQ: _____ DATE OF LAST TETNUS SHOT (MM/DD/YYYY):_____

	Class	Day	Time	Term 3
☐	DragonFly® Beginners	Wednesdays	9:30 - 11:15am	$160
☐	DragonFly® Tuesday		☐ 8:30am - 4:30pm (ages 12 to 20) ☐ 8:30am - 1:00pm (ages 7 to 12)	$930 $525
☐	DragonFly® Friday		☐ 8:30am - 5:30pm ☐ 10:00am - 5:30pm ☐ 1:30pm - 5:30pm	$1,110 $930 $525
☐	DragonFly® Lunch Club	Saturdays	11:30am-1:00pm	$105
☐	DragonFly® Photography	Saturdays	1:00pm-2:00pm	$140

Yes	No		Yes	No	
		Allergies			Easy Bleeding
		Food			Emotional/Psychiatric/Behavioural Problems
		Stings/Bites			Hearing Loss/Hearing Aid
		Medicine			Heart Disease or Defect/High Blood Pressure
		Asthma			Heat Stroke/Exhaustion
		Blindness/Visual Problems			Major Surgery or Serious Illness
		Bone or Joint Problem			Medications (If yes, list below)
		Chest Pain			Non-verbal
		Concussion or Serious Head Injury			Seizures/Epilepsy/Fainting Spells
		Diabetes			Requires Assistance
		Down Syndrome			Uses Wheelchair
		Atlanto-Axial X-Ray Result _____			Other: _____

Please list medications and dosage. Please explain any medical issues and how to address them (e.g. list any allergies, response to seizures, medication required for specific circumstances etc.). Please attach any additional information required.

SIGNATURE:_____**DATE:**_____
(Parental signature required)

VISA/Mastercard #: _____**Expiry Date:** _____

Name on VISA/Mastercard:_____

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