** SHOW CALL ACADEMY OF PERFORMING ARTS**

**REGISTRATION FORM**

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| **PARENT / GUARDIAN /CARER DETAILS** | | | |
| FIRST NAME |  | SURNAME |  |
| ADDRESS |  | HOME TELEPHONE |  |
| MOBILE |  |
| EMAIL |  |
| *PLEASE PROVIDE US WITH FURTHER DETAILS IF STUDENTS ADDRESS IS DIFFERENT TO THE ABOVE* | | | |

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| **ALTERNATIVE CONTACT** | | | |
| FIRST NAME |  | SURNAME |  |
| MOBILE |  | HOME TELEPHONE |  |
| RELATIONSHIP TO STUDENT: | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **YOUR CHILDS DETAILS** | | | |
| **FIRST NAME** |  | **SURNAME** |  |
| **KNOWN AS** |  | **DATE OF BIRTH** |  |
| **GENDER** | GIRL □ BOY □ NON-BINARY □ OTHER □ | **AGE** |  |
| **MEMBERSHIP** | INITIAL CHILD □ SIBLING □ | | |

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| **MEDICAL CONDITIONS** | |
| *PLEASE LIST ANY MEDICAL CONDITIONS YOUR CHILD HAS THAT WE SHOULD BE AWARE OF*  *[WE MAY NEED TO DISCUSS THIS WITH YOU AND GET FURTHER INFORMATION]* | |
| 1. | 3. |
| 2. | 4. |
| **PLEASE NOTIFY US OF ANY ALLERGIES:** | |

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| I HAVE READ AND AGREE TO THE SHOW CALL ACADEMY OF PERFORMING ARTS **TERMS AND CONDITIONS** *(These can be found at the bottom of the contact page on the Show Call Academy of Performing Arts website)****.* In addition I agree to:**   * MY CHILDS IMAGE BEING USED ANONYMOUSLY IN ANY PUBLICITY MATERIAL, INCLUDING BUT NOT EXCLUSIVELY BROCHURES, VIDEOS, WEBSITE AND SOCIAL MEDIA. * AUTHORISE SCAPA STAFF TO CALL FOR MEDICAL HELP IF UNABLE TO CONTACT ME AND ACT ON MY BEHALF. * SCAPA STAFF TO ADMISTERING BASIC FIRST AID IF NECESSARY. * I UNDERSTAND THAT 4 WEEKS NOTICE OF INTENTION TO LEAVE IS REQUIRED (IN WRITING) AND THAT ANY REFUND OF PAYMENTS ALREADY MADE WILL BE AT THE SOLE DISCRETION OF THE MANAGEMENT OF SHOW CALL ACADEMY OF PERFORMING ARTS. * MAKING EACH INVOICE PAYMENT BY THE DATE SPECIFIED WITHIN THE INVOICE.   *(Rates work out at £4.40 per hour, £11.00 per week. Invoices are sent out before the start of each new term and can be payed in one full termly payment or in equal monthly instalments. These are worked out by dividing the amount of sessions in the term by the amount of months in the term.)* | |
| NAME: |  |
| SIGNED: |  |
| DATE: |  |

THE PERSONAL DATA PROVIDED INTHIS FORM WILL BE PROCESSED UNDER THE TERMS DEFINED BY THE **GENERAL DATA PROTECTION REGULATION (GDPR) (EU) 2016/679** FOR THE PURPOSES OF ADMINISTRATION, RESEARCH, AUDIT AND IN LINE WITH STATUTORY LEGISLATION REGARDING CHILDREN. WE WILL NEVER SHARE INFORMATION TO THIRD PARTIES FOR MARKETING PURPOSES. BY SIGNING THIS FORM YOU CONSENT TO THE USE OF THIS PERSONAL INFORMATION FOR THESE PURPOSES.