

Dancing with the **ZEBRAS**

What is it? Claremore Varsity Dance Team is hosting a mini-clinic! The girls who sign up will have the opportunity to dance with the Claremore Varsity Dance Team at a High School Basketball game HALF-TIME (home game)!

When is it? **Clinic:** February 4th OR 10th 7pm-8:30pm with door opening at 6:30pm (you only have to attend one but can attend both)
Performance: February 11th @ Varsity Basketball Girls game. Game starts at 6 p.m. check in around 5:45-6 at the Mobra Gym. Girls will need to be picked up at the same location as drop off.

Who is it for? Kindergarten-6th Grade

Cost: \$25 per dancer if registered by January 31st
\$30 per dancer if registered by February 4th at the clinic. After the 4th a T-shirt can not be guaranteed.

Includes clinic T-shirt (which will be worn at performance- Select size on back)

****Please make checks out to "CHS". This is a fundraiser****

Deadline: February 10th **SPOTS ARE LIMITED!**

What to bring and where: For clinic, each dancer will need to wear shorts/t-shirt. Each dancer will need to wear black pants and their clinic shirt to performance. Practice will be held in high school gym.

FORMS CAN BE TURNED INTO THE FRONT OFFICE AT THE HIGH SCHOOL

If you have any further questions, please email Coach Warden

jwarden@claremore.k12.ok.us

Claremore High School Dance Team Mini Clinic

NAME: _____ Grade: _____ (K-6th Only)

SCHOOL: _____

ADDRESS: _____ PHONE: _____

T-SHIRT SIZE: (PLEASE CIRCLE) YS YM YL AS AM AL AXL

☐ AUTHORIZATION FOR EMERGENCY TREATMENT

I hereby authorize any emergency physician, surgeon, medical staff, dentist or dental specialist on the medical staff of Claremore Regional Hospital, Claremore Indian Hospital, (U.S. Government) or such other named hospital and their medical staff and emergency physicians, to administer any and all emergency treatment, procedure, or medicines necessary or advisable when school officials accompany

(student's name) _____ to the emergency room. I further agree to pay such hospital, doctors, medical staff and ambulance service for all services rendered to the above named child.

I request that this authorization remains in full force and effect as long as my child is a student in Rogers County Independent School District No. 1, Rogers County, Oklahoma.

Dated this _____ day of _____ 2020

PARENT/GUARDIAN (Print Name)*

PARENT/GUARDIAN SIGNATURE

*Please circle above whether you are the parent or guardian. NOTE: A step-parent is not sufficient. It must be a biological or adoptive parent. If guardian include the following:

Court Jurisdiction _____ Case# _____

List adults other than parents whom we should call in the event of an illness or emergency when the parents cannot be reached.

NAME

RELATIONSHIP

PHONE

WORK _____

HOME _____

Please check the following:

_____ MY CHILD HAS NO KNOWN MEDICAL CONDITIONS OR ALLERGIES:

CIRCLE THE FOLLOWING MEDICAL CONDITION OR ALLERGIES OUR CHILD HAS:

Allergy to medication/food/bees, etc.

Irritable Bowel Syndrome

Asthma/lung condition

Joint/Muscle condition

Diabetes

Migraines

Heart Condition

Neurological/Seizures

Current Medications _____

Please list symptoms of condition: _____