ALL Abilities Center

Group Art Registration & Contract

Name(s)_____ D.O.B._____

Address_____

Phone #_____ Cell #_____

E-mail Address_____@_____

Parent/Guardian_____

In Case of Emergency Contact_____

FI: (if applicable)_____

Class: Group Art
Time: 5:00 – 5:45
Cost: $130.00 per month/$35.00 for a single day
Location: 170-1 Wilbur Place, Bohemia, NY 11716

Liability Release: I or We Agree That: In consideration of this program, allowing myself or our child's participation in the activities, under the terms set forth herein, I or We, the parents, for ourselves or on behalf of our child or children and/or, heirs, administrators, personal representatives, or assigns, do agree to hold harmless, release, and discharge All Abilities Corp., its owners, officers, directors, agents, employees, representatives, assigns, members, owners of premises, affiliated organizations, insurers and others acting on its behalf, of and from all claims, demands, causes of action and legal liability, whether the same be known or unknown, anticipated or unanticipated, due to All Abilities Corp. and/or its associates ordinary negligence; and I or We, the parents, do further agree that except in the event of gross negligence and willful and wanton misconduct, shall not bring any claims, demands, legal actions and causes of action, against All Abilities Corp., its associates as stated above in this clause, for any economic and non-economic losses due to bodily injury, injuries incurred from teaching and/or reward material used during instruction or personal use, death, property damage, sustained by me or my minor child or legal ward in relation to the premises and operations of All Abilities Corp., whether on or off the premises. Payment is due in full prior to all classes (except in the case of Self-Direction). The Client understands that he/she shall be charged regardless of attendance until such time that this contract is canceled in writing (applies to monthly members). The Clients understand that if Self-Direction does not pay for any reason, they are responsible for payment in full.

Client Signature_____ Date_____

Parent/Guardian Signature_____ Date_____
(only required in the event the client is a minor or incapable of executing a contract)

www.ALLAbilitiesCenter.org | 1 (877) 396-HOPE | (631) 615-6707 | E-Mail: Info@ALLAbilitiesCenter.org
1784 Hempstead Turnpike, E. Meadow, NY 11554 | Locations in Nassau & Suffolk

ALL Abilities Center

Name_____

What is you or your child's primary form of communication? (Ex. English, ASL, Spanish, AAC device, etc.)

_____

Please advise as to any medical condition and/or behavioral issues that the instructor should be made aware of:

_____

_____

Do you or your child experience seizures?

_____

What are you or your child's areas of need?

_____

_____

What are you or your child's strengths?

_____

Do you or your child receive any therapies (OT, PT, Speech, etc.) at home or at school?_____

Any additional information The All Abilities Center and/or instructor should be made aware of?

_____

_____

What are you or your child's art preferences? (drawing, painting, clay, etc.)

_____

_____

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