

DANCE FACTORY



2010 Certificate II Application Form



DANCEFACTORY

GENERAL									
First Name					Last Name				
Date of Birth					Age as of 01/01/10				
How did you hear about Dance Factory? (Please circle)									
Internet		Dance Train		Dance Australia		Word of mouth		Other? (please specify)	
Height		Weight		Sex M / F (Please Circle)		Languages Spoken			
Emergency Contacts									
Name				Phone 1			Phone 2		
ADDRESS									
Street Number & Name									
Suburb						State		Postcode	
Telephone		Home			Mobile			Fax	
Email address									
Health Insurance									
Do you currently have private health insurance? (please tick)									
Hospital			Extra			Neither			
Which course would you prefer?					Day / Evening (Please circle)				
ADVERTISING									
Please sign here to give Dance Factory permission to use your name for advertising and marketing purposes									
Signature _____									
OFFICE USE ONLY									
Paid App Fee		Audition Letter		Accept Letter		Paid 1 st term		Confirm Letter	
Paid Costume		Austudy Letter		Signed Agree		Student ID			

Dance Training

Please fill in all your previous training; it is not essential to have had prior experience in all these units.

Style of dance	Years of Training	Hours per week	School's name	Teachers
JAZZ				
Age started				
CLASSICAL				
Age started				
FUNK				
Age started				
TAP				
Age started				
SINGING				
Age started				
DRAMA				
Age started				
ACROBATICS				
Age started				
OTHER				
Age started				

List your other commitments outside of school hours including work and hobbies.

Education (Australian students only)

What is your highest COMPLETED school level? (please tick)

Year 12	<input type="checkbox"/>	Year 11	<input type="checkbox"/>	Year 10	<input type="checkbox"/>	<Year 10	<input type="checkbox"/>
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In which year did you complete that level?

Please list any completed qualifications

Aims

What do you hope to achieve by doing this course?

Medical Examination

This section of the application is to be completed by a medical practitioner

PATIENT'S GENERAL DETAILS			
Surname		First Name	
Height	Weight	Date of Birth	
Sex (please circle) M / F	Blood Pressure (please circle)	Average	Low High
Eyesight (please circle) Good Impaired	Hearing (please circle) Good Impaired		
PATIENT'S MEDICAL HISTORY			
Has the patient ever suffered from any of the following conditions? (please circle)			
Allergies	Arthritis	Asthma	Hepatitis
Glandular Fever	Diabetes	Epilepsy	Heart Disease
Has the patient ever injured or suffered pain in any of the following areas? (please circle)			
Ankles/Feet	Knee	Hamstring	Groin
Back	Neck	Shoulder	Hip
Is there evidence of any irregularities in the following areas which may affect the patient's ability to dance?			
Musculoskeletal System	Respiratory System	Nervous System	Cardiovascular System
Has the patient ever been hospitalised?		Is the patient currently taking any medication?	
If you have circled any if the above please give details			
Do you consider the patient to undertake full time dance training? (26hrs p/week)		YES / NO	
Do you consider the patient to undertake part time dance training?(10hrs p/week)		YES / NO	
If not, please provide more details			
Name of Doctor (Please Print)			Date / /
Signature		Contact Phone Number	
Registration No.			