



*Motion Magic*  
Inspiring a lifelong love of movement

Motion Magic Afterschool Class at PVS Registration Form

Please fill out this registration form, save it to your computer under a new name, attach it to an email and send to [morgan@motionmagic.net](mailto:morgan@motionmagic.net). Leave the signature parts blank and you can sign them on the first day of the session. You can also print out the form and send it to the following address along with your check. Checks must be made payable to Motion Magic.

Motion Magic  
5225 NE Garfield Ave.  
Portland OR 97211

If you need to arrange a payment plan or bring the check on the first day of the session, please contact [morgan@motionmagic.net](mailto:morgan@motionmagic.net) to make these arrangements.

For more information you can email [morgan@motionmagic.net](mailto:morgan@motionmagic.net) or call 503-975-8647.

Student Name: \_\_\_\_\_ Age: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Address: \_\_\_\_\_

I hereby give permission for my child to participate in Motion Magic Afterschool class.

Parent/Gaurdian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please list all people who are authorized to pick up your child aside from the parent/guardian:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name \_\_\_\_\_ Relationship: \_\_\_\_\_

**Emergency Information:**

Child's Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Child's Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

In case of an emergency contact (if parent unreachable):

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Allergies \_\_\_\_\_

Any other conditions we should be aware of?: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_

**Consent for emergency care:** I hereby grant permission to Motion Magic teachers to perform emergency care, including first aid and CPR on my child and transport my child as deemed necessary for further medical treatment in the event I am unable to be contacted. I further consent to medical or surgical treatment by any licensed physician and or hospital and the administration of surgeries and any other medical treatments deemed necessary or advisable in the event I am unable to be contacted.

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_