



DANCE ACADEMY

# 2018-19 Release & Treatment Authorization Form

Ballet Metropolitan Inc. \_\_\_\_\_ Downtown \_\_\_\_\_ MAC

*This form must be completed to participate in all BalletMet activities!*

\_\_\_\_\_  
(Print Name of Participant)

I am aware that dancing and the exercises associated with it may place unusual stresses on the body and carry with then the risk of physical injury. On behalf of my child and myself (and, if I am no longer a minor, on my own behalf), I assume this risk and agree that Ballet Metropolitan, Inc. ("BalletMet") shall not be liable in any way for injuries sustained during participation in BalletMet activities or any of its related functions. This instrument is given on my own behalf if I am the participant and on behalf of my child and myself, if my child is the participant, and extends to our executors, administrators, heirs and assigns.

I grant my child or ward permission to participate in BalletMet activities. I hereby release and discharge BalletMet, its agents, employees, representatives, trustees, and officers (collectively BalletMet Representatives) from all claims, demands, actions, judgments, and executions which I, the participant and our heirs, executors, administrators or assigns may have, or claim to have, against BalletMet, their successors or assigns for all claims for loss, damages, expenses, and personal injuries caused by or arising from, the participants participation in BalletMet activities or any activities related thereto. I also agree to hold harmless and indemnify the BalletMet Representatives from and against any and all claims, including claims of negligence, which arise in any manner out of the participant's participation in the BalletMet activities. I understand that by signing this instrument, I would ultimately bear the loss is I should successfully sue and recover damages from the BalletMet Representatives.

I understand and agree the BalletMet may create recordings during the activities by photo, video, digital recording, or otherwise. I authorize BalletMet to use such recordings for any purpose they deem. Uses may include publicity, promotions editorial, and related marketing purposes.

Further, I grant BalletMet, its agents, and employees permission to authorize any emergency medical treatment that may be required for my child or ward during BalletMet activities.

**\*PLEASE SEND A PHOTOCOPY, FRONT/BACK, OF YOUR MEDICAL INSURANCE CARD\***

I, the undersigned, have read this release/authorization and understand all of its terms. I execute it in consideration of BalletMet allowing the participant to participate in the activities, voluntarily and with full knowledge of its significance. I have executed this release/authorization on the date stated below.

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date: MM/DD/YY

\_\_\_\_\_  
Signature of Parent or Guardian (If participant is under 18 years of age)

\_\_\_\_\_  
Date: MM/DD/YY

**Please print names and Phone number where Parent/Guardians can be reached:**

Name of Signing Parent/Guardian: \_\_\_\_\_

Contact # Day: \_\_\_\_\_ Eves: \_\_\_\_\_ Cell: \_\_\_\_\_

Name of Spouse/Guardian: \_\_\_\_\_

Contact # Day: \_\_\_\_\_ Eves: \_\_\_\_\_ Cell: \_\_\_\_\_

Emergency Contact (Other than listed above)

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

Contact # Day: \_\_\_\_\_ Eves: \_\_\_\_\_ Cell: \_\_\_\_\_

Participants Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

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

Has the participant sustained any previous injuries that may be aggravated by intense work, or are there any medical conditions that BalletMet should be aware of? Yes \_\_\_\_\_ No \_\_\_\_\_ Please Explain: \_\_\_\_\_

Is the participant currently requiring treatment, therapy, or taking any medications for any injury or medical condition?

Yes \_\_\_\_\_ No \_\_\_\_\_ Please Explain: \_\_\_\_\_

BalletMet will not dispense medications. Students should bring their own supply of any over the counter medications with them in the original containers. Any dosage request that exceeds the printed instructions must have separate instructions and approval from Parent/Guardian.

The participant has my, (Parent/Guardian Initials) \_\_\_\_\_ permission to take the below stated medications:

- Ibuprofen (i.e. Advil, Motrin, etc.) Reason: \_\_\_\_\_
- Acetaminophen (i.e. Tylenol) Reason: \_\_\_\_\_
- Other & Reason: \_\_\_\_\_

The Participant has allergies to the following:

- Food: \_\_\_\_\_
- Medicine: \_\_\_\_\_
- Substances: \_\_\_\_\_
- Other: \_\_\_\_\_

### Optional

When applying for funding and grants, we are often asked for the demographics of our population. Below are the categories that many times are requested from us. If you would be willing to help us by including this information, it would assist us in giving the most accurate information possible. We thank you for your assistance! **Please check all that apply**

\_\_\_\_\_ AIAN (American Indian-Alaskan Native)

\_\_\_\_\_ APP (Appalachian)

\_\_\_\_\_ ASI (Asian)

\_\_\_\_\_ BAA (Black/African America)

\_\_\_\_\_ HL (Hispanic/Latino)

\_\_\_\_\_ NHPI (Native Hawaiian-Pacific Islander)

\_\_\_\_\_ PWD (Person with Disability)

\_\_\_\_\_ CY (Children and Youth, Under 18 years of age)

\_\_\_\_\_ CA (White/Caucasian)

\_\_\_\_\_ SR (Senior Adult, 62 years of age or older)