

DANCER EMERGENCY TREATMENT FORM 2019 - 2020

Dancer's Name _____ Date of Birth _____

Allergies _____

Mom's Information

Name _____ Place of Employment _____

Home Addresses: _____ City _____ State _____ Zip _____

Phones: Home _____ Work _____ Cell _____

Permission to Text ____ Yes or ____ No Cell Carrier _____ Email: _____

(Verizon, Sprint, etc...)

Dad's Information

Name _____ Place of Employment _____

Home Addresses: _____ City _____ State _____ Zip _____

Phones: Home _____ Work _____ Cell _____

Permission to Text ____ Yes or ____ No Cell Carrier _____ Email: _____

(Verizon, Sprint, etc...)

Other contact's Information

Name _____ Relationship to dancer _____

Home Addresses: _____ City _____ State _____ Zip _____

Phones: Home _____ Work _____ Cell _____

Health Insurance

Company _____ Policy #: _____ Physician _____ Phone _____

If your child requires a visit to the hospital while under the supervision of Ballet Arts, Inc., a Ballet Arts Director can authorize treatment if you have consented by signing below.

By signing below, I hereby consent to allow:

_____ a Ballet Arts Director to authorize any needed medical treatment for this dancer in my absence.

_____ my child to dance with Ballet Arts of Jackson, Inc. and to allow my child's picture to appear in marketing/publicity materials published by Ballet Arts of Jackson, Inc. for the general public including the Ballet Arts' website and social media.

Furthermore, I hereby waive any claim against Ballet Arts of Jackson, Inc., its Board of Directors, agents, or the dancing school where company classes or rehearsals are given in the event of any injuries incurred during rehearsals, performances, company classes, or any other Ballet Arts of Jackson, Inc. activity.

Signed _____

Relationship to Dancer _____

Signed _____, Dancer if over 18