

SCHOOL OF CANTON BALLET

MEDICAL AUTHORIZATION FORM

Please attach a copy of your insurance card

Student's Name _____ Parent's Name(s) _____

Address _____ City/Zip _____

Phone _____ Other phone _____ Cell _____

Purpose: To enable parents and guardians to authorize the provisions of emergency treatment for students who become ill or injured while under Canton Ballet authority, when parents or guardians cannot be reached.

In the event reasonable attempts to contact me at _____ (Phone) or _____ or _____ (Cell(s) have been unsuccessful. I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. _____ (preferred physician) at _____ (physicians phone) or Dr. _____ (preferred dentist) at _____ (dentist phone), or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of student to _____ (preferred hospital) or any hospital reasonably accessible. The authorization does not cover major surgery unless the medical options of two licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the medical history including allergies, medications being taken and any physical impairment to which the physician should be alerted: _____

Signature of Parent or Guardian or Applicant over 18 years of age

Date _____

EXTRA CURRICULAR ACTIVITES

The student listed above has my permission to participate in extra curricular activities with School of Canton Ballet, traveling by car, bus or plane during this school year. I release and agree to indemnify the Canton Ballet for any and all liability claims while the registrant is en-route to and from and attending with Canton Ballet.

Signature of Parent or Guardian or Applicant over 18 years of age

Date _____

TO ADMINISTER OVER THE COUNTER MEDICATIONS

_____ Yes, I do give permission to (chaperone or director) administer to my child over the counter medications and instructions you would like Canton Ballet staff to administer: _____

_____ No, I do not give permission for medication to be administered.

Signature of Parent or Guardian or Applicant over 18 years of age

Date _____

MODEL RELEASE FOR ALL STUDENTS

I (undersigned) hereby grant to Canton Ballet the right and unrestricted permission to use, re-use, display, distribute, transmit, publish, re-publish and/or copy, either in whole or in part, either digitally, in print or in any other medium now or hereafter known, for any purpose whatsoever, without restrictions, and without regard to my child's future status as a student of Canton Ballet, photographs taken of my child, or in which my child may be included; to alter the same without restrictions; and to copyright the same. I understand and agree that Canton Ballet may or may not use my child's name in conjunction with the photographs as they so chooses and that no remuneration will be made to me for the use of the photographs. I understand that Canton Ballet will use discretion in using my child's name and will not, at any time, release any contact information for my child unless separately authorized by me.

Consent. I represent that I am the legal guardian of the child named herein and that I have read the foregoing and fully understand its content. This release shall be binding upon me, my heirs, legal representatives and assigns. **Entire Agreement.** This Agreement contains the entire agreement between the parties relating to the subject matter hereof and supersedes any and all prior agreements or understanding, written or oral, between the parties related to the subject matter hereof. No modification of this Agreement shall be valid unless made in writing and signed by both of the parties.

Signature of Parent or Guardian or Applicant over 18 years of age

Date _____