Permission to Participate and Release of Claims Form

PURPOSE: Permission to participate and release of claims incurred from participation in dance and dance-related activities associated with Natalya's Turning Pointe School of Dance.

Please note: inconsistent attendance, poor nutrition, lack of sleep and rest increase the risk of juries.

STUDENT'S NAME ____

PARENT'S NAME (S) ______________________________________

I grant my child/ ward or myself, ______________________________, permission to participate in The Turning Pointe School of Dance and/or activities of The Turning Pointe School of Dance, classes and performances. I hereby release and discharge Natalya's Turning Pointe School of Dance, its successors, or assigns for all personal injuries caused by, or arising from the above described activities or any activities related thereof.

DATE ________________ ____
Signature of Participant or Parent/Legal Guardian

Medical Authorization

PURPOSE: To enable parents and guardians to authorize the provisions of emergency treatment for students who become ill or injured while under The Turning Pointe School of Dance authority, when parents or guardians cannot be reached.

In the event reasonable attempts to contact me at _________________ (phone number) or _________________ (second phone number) have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by Dr. ______________(preferred physician) at ______________(phone number) or Dr. ____________________(preferred dentist) at _____________(phone number), 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.

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DATE ________________ Signature ____
(Participant or Parents/Guardian if a minor)