

Emergency Information & Travel Authorization 2018-2019

Student's Name

Home Phone Number

Parent's Name(s)

Home Address

Parents' Cell Phone (s) - *Please list **all** that apply.*

People to call (not listed above) in case of an illness or emergency:

Name

Relationship

Phone Number

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Travel Authorization

I hereby give my consent for the above named student to travel to and from events scheduled by Dublin Dance Centre & Gymnastics. I understand that private transportation will be used. These vehicles will be driven by responsible adults (parents of dancers or DDC&G staff members) or by an insured transportation company and they will not be held responsible for any accident or injury that may occur.

Parent Signature _____ Date _____

dublin DANCE centre
& GYMNASTICS
dublindance.com 614-761-2882

Emergency Medical Authorization

Parents, You **Must** complete Part I OR Part II

Part I (To Grant Request)

In the event that reasonable attempts to contact me or the other parties listed herein have been unsuccessful, I hereby give my consent a) for the administration of any treatment deemed necessary by our preferred physician or dentist, or in the event that the designated preferred practitioner is not available, by another licensed physician or dentist, and b) for the transfer of the child to our preferred hospital or any other hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring the necessity for such surgery, are obtained before surgery is performed.

Preferred Doctor _____

Phone Number _____

Preferred Dentist _____

Phone Number _____

Preferred Hospital _____

Please list any facts concerning the student's medical history, including allergies, current medications, and any other impairment to which a physician should be alerted:

Parent Signature _____

Date _____

Part II (Refusal to grant consent to treatment)

(DO NOT complete this section if you have completed Part I)

I DO NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring treatment, I wish Dublin Dance Centre authorities to take no action or to do the following:

Parent Signature _____

Date _____

Insurance Verification / Waiver

Parents, You **Must** complete Part I OR Part II

Part I – Verification

Insurance Company _____

Policy Number _____

I attest that a medical insurance policy is in place for my child, and that the above named insurance company will pay the medical or surgical expenses that result from any injury, major or minor, that the student may receive as a result of practicing or performing with the Dublin Dance Centre. This insurance will also cover the student while traveling to performances or conventions away from the Dublin Dance Centre facilities.

Since the student is covered by an insurance policy which will provide adequate financial coverage for any type of injury which may result, I the parent, or guardian agree to release Dublin Dance Centre from any obligations which pertain to financial responsibility in these matters.

Parent Signature _____

Date _____

Part II – Waiver

I hereby acknowledge that an accident insurance policy is not in force for the student. Since this student is not covered by an insurance policy which will provide adequate financial coverage for any type of injury, I the parent or guardian, agree to release Dublin Dance Centre from any obligations which pertain to financial responsibility in these matters.

Parent Signature _____

Date _____