

The Turning Pointe



School of Dance

2008-2009
School Year

Home of the OHIO YOUTH BALLET & DANCE TEAM
2387 Locust St. S., Canal Fulton OHIO 44614

PERMISSION TO PARTICIPATE AND RELEASE OF CLAIMS FORM

STUDENT'S NAME _____
PARENT'S NAME (S) _____
ADDRESS _____ CITY _____ ZIP CODE _____ PHONE _____

PURPOSE: Permission to participate and release of Claims incurred from participation in dance and dance related activities associated with The Turning Pointe School of Dance.

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 Teresa M. Irion DBA The Turning Pointe School of Dance, it's 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

The Turning Pointe School of Dance



2007-2008
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MEDICAL AUTHORIZATION FORM

STUDENT'S NAME _____
PARENT'S NAME(S) _____
ADDRESS _____ CITY _____ ZIP CODE _____ PHONE _____

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

-Please Complete -

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. _____

DATE _____ Signature _____

(Participant or Parents/Guardian if a minor)