Emergency Information & Travel Authorization

_____ _____

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
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 _____