FORMS

F2. MEDICAL INFORMATION AND RELEASE

Mail completed registration packets to:
Attn: Education Department / Summer Intensive
Society for the Performing Arts
615 Louisiana Street, Ste. 100
Houston, TX 77002
Or, scan and email to: education@spahouston.org
Or, fax to: 713-632-8122

Name of Program: 2017 Ballet Hispanico Summer Dance Intensive

Participant's Name: _____ Date of Birth: _____

To be completed and signed by the Adult Participant or Parents/Guardians of Minor Participant.

Certification of Physical Condition and Medical Consent:

Each person who signs below certifies and agrees as follows:

I hereby certify that Participant is suited to participate in the Program activities and Participant does not have any impairment that would adversely affect Participant's health or well-being while participating in the Program. I understand that Society for the Performing Arts ("***SPA***") will attempt to contact an Emergency Contact listed below should Participant require medical attention while participating in the Program. I authorize SPA staff to arrange for medical treatment if necessary. I authorize SPA to release the information contained in this document to a third party medical provider. I assume responsibility for payment of all charges in connection with medical treatment of any injury or illness that occurs while the Participant is participating in the Program. I agree to promptly reimburse SPA for any amounts that SPA expends on Participant's behalf for any medical care, expenses, transportation costs, damages, or loss incurred while Participant participates in the Program. I certify that information set forth below is correct.

Emergency Contacts

In the event of an emergency, please contact:

Name:_____PhoneNumber(s): _____
Relationship to Participant: _____

Name: _____Phone Number(s): _____
Relationship to Participant: _____

Medical Conditions

Medical Condition(s), if any, that are pertinent to Participant's participation in the Program: _____

Allergies: _____

Medications

I acknowledge that SPA will not administer or supply any type of medication during the Program. Participant is responsible for his/her own medication and for taking the prescribed dosage. Medications that Participant will be taking during participation in the Program:

_____

Medical Insurance (the following is to be completed if Participant has medical insurance)

I certify that Participant has medical insurance with the company listed below.

Insurance Co.: _____ Telephone No.: _____

Group No.: _____ ID No.: _____ Name of Primary Insured: _____

Family Physician

Family Physician: _____Phone Number: _____

Address: _____

SIGNATURES OF PARENTS/GUARDIANS IF UNDER 18:

By: _____
Printed Name of Parent/Guardian:
_____

Relationship to Participant: _____
Date: _____

By: _____
Printed Name of Parent/Guardian:
_____

Relationship to Participant: _____
Date: _____

SIGNATURE OF PARTICIPANT IF 18 OR OLDER: _____

Date: _____