



MEDICAL CONSENT/RELEASE FORM

For and in consideration of the participant's being allowed to participate in events and activities relating to Festival Dance Camp (FDC):

As the parent/legal guardian of _____, I request that in my absence representatives of FDC may seek to admit the above named child to any hospital or medical facility for diagnosis and treatment in the event that he/she suffers any injury while participating in the FDC program. FDC may request and authorize physicians, nurses, dentists and staff, to perform any diagnostic procedures, treatment procedures, and operative procedures to the above named child. I have not been given any guarantee as to the results of any treatment if performed on the above named child.

I hereby accept any financial responsibility for any and all medical treatment necessary to be administered to the above named child in the event of an accident, injury, sickness, etc. Any representative of the FDC is designated to act in my behalf until I have been contacted.

General Release

I understand the above named child assumes any and all risks that might be associated with the activities of Festival Dance Camp that he or she may be involved in and hereby relinquishes and releases any and all liability for any cause of action for personal injury, property damage or wrongful death occurring to participant arising out of participation in activities incidental thereto, wherever or however they occur and for such period said activities may continue, and by this agreement any such claims, rights and causes of action ("Claims") that participant may have are hereby relinquished and released by the participant and the parent(s)/guardian(s) do so on behalf of the participant's heirs, executors, administrators and assigns or as any of the foregoing may have against FDC, its agents, employees, affiliates, directors, teachers and representatives for any and all such Claims of any kind as a result of their participation.

Date of birth ___/___/___ for the above named individual.

Known allergies and reactions of the above named individual, including any allergies to

Any other special medical problems that should be noted about the above named individual.



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Please list any medications that your child will be bringing with them.

Family Physician: _____ Phone Number _____

Names of Parents/Guardians: _____

Address: _____

City/State/Zip _____

Phone: H _____ W _____ Other _____

Person Responsible for charges (if different than above) _____

Address: _____

City/State/Zip _____

Phone: H _____ W _____ Other _____

Other Person to Notify if parent/guardian is unavailable _____

Phone: H _____ W _____ Other _____

Insurance Company _____ Policy or Group Number _____

Signature of Parent/Guardian _____

Date _____