

**PARENTAL AUTHORIZATION FOR TREATMENT OF A MINOR CHILD**

I am the parent with legal custody or legal guardian for \_\_\_\_\_ (“my child”) and hereby give permission for my child to participate in dance classes and any and all other activities related to the Annapolis Dance Factory, LLC. In the event my child becomes ill or is injured, I authorize the instructor(s) to take the following action:

1. Contact a parent of the minor and follow his/her instructions.

Home Phone: (\_\_\_\_)\_\_\_\_\_

Father’s Name: \_\_\_\_\_ Father’s Cell Phone: (\_\_\_\_)\_\_\_\_\_

Mother’s Name: \_\_\_\_\_ Mother’s Cell Phone: (\_\_\_\_)\_\_\_\_\_

2. If we are unavailable, please contact the following person(s):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: (\_\_\_\_)\_\_\_\_\_ Cell Phone: (\_\_\_\_)\_\_\_\_\_

3. If no one listed above can be reached in the event of an EMERGENCY, or if my child becomes seriously ill or injured and in the discretion of Annapolis Dance Factory requires prompt medical attention and I am not available to give my consent, I hereby give my permission for Annapolis Dance Factory to secure medical treatment and for any medical provider contacted by Annapolis Dance Factory to provide services reasonably thought necessary for my son or daughter, including transport, evaluation, treatment, and if necessary, hospitalization, injection(s), medication(s), blood transfusion(s), anesthesia and/or surgery for my child.

Known Medical Conditions and Drug Reactions:

\_\_\_\_\_  
\_\_\_\_\_

My child’s date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Medical Insurance Carrier: \_\_\_\_\_; Policy # \_\_\_\_\_

Hospitalization Carrier (if different): \_\_\_\_\_; Policy # \_\_\_\_\_

Is your child currently taking any medications? Yes **or** No

If Yes, what medications are they taking? \_\_\_\_\_

Copy of insurance card attached? Yes **or** No

I, \_\_\_\_\_, am the legal guardian of, \_\_\_\_\_.

(Parent/Legal Guardian)

(Participant)

I hereby consent to allow my child to participate in Annapolis Dance Factory classes and/or events and authorize emergency medical treatment as outlined above. I release and hold harmless anyone who acts in reliance on this authorization.

\_\_\_\_\_  
(Signature of Parent/Legal Guardian)

\_\_\_\_\_  
(Witness)

\_\_\_\_\_  
(Print Name of Parent/Legal Guardian)

\_\_\_\_\_  
(Date)