# Eglevsky Ballet

**Medical Authorization Form**

700 Hicksville Road, Suite 102
Bethpage, NY 11714
516-746-1115

Student Name__________________________ Sex_____ Date of Birth_________

Emergency Contacts:
Name____________________Relationship______________Phone Number______________

Name____________________Relationship______________Phone Number______________

**Medical Emergency Release:**

It is our firm hope that the authorization granted on this form will never be used. However, for the safety of the participant, sound medical practice calls for such authorization. **This form will only be used in an emergency and only after every attempt has been made to contact the parent/guardian first.** Doctors and hospitals refuse to give any treatment, regardless of how minor, without authorization from the parent/guardian. The law requires that a student signature or that of the parent or guardian if the student is under 21, must be notarized.

I represent that I am the parent/legal guardian for the above-designated student, who is a minor, and I hereby empower the Eglevsky Ballet to act on my behalf in case of emergency Permission is hereby extended to the medical professionals selected by the Eglevsky Ballet to provide all necessary emergency medical attention, including anesthesia and surgery. **Please include a copy of front and back of insurance card**

__________________ ____________________________________ __________

Student signature Signature of parent/legal guardian (if under 21) Date

**General Injury Release:**

In consideration of the participation of the student named in this Medical Authorization Form in Eglevsky Ballet's Training Program, I personally, as the participating student, or the parent or guardian of such student, intending to be legally bound, do hereby, for myself, my heirs, executors, and administrators, waive and release Eglevsky Ballet Company of Long Island, Inc., their officers, representatives, successor, and/or assigns for any and all damages which may be sustained or suffered by me in connection with my association with the above program, or any activities related thereto, including without limitation, my traveling to or participating in and returning from any activity associated with the program.

__________________ ____________________________________ __________

Student signature Signature of parent/legal guardian (if under 21) Date

***This Form Must Be Notarized***

***STATE OF NEW YORK )***

SS.:

COUNTY OF )

On this ___________day of _______________, 20____, before me personally came ___________________________________, to me known and known to me to be the person described in and who executed the foregoing instrument and he/she acknowledged to me that he/she executed the same.

___________________________

Notary Public

**Eglevsky Ballet**
**Doctor's Medical Report**

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Student Name___________________________ Sex_____ Date of Birth_________

Height________ Weight________ Blood Pressure________ Pulse_______

Does this child take any medication on a regular basis (please specify name of medication and dose)?__________________________________________________________________________

Has this child had any injury or operation? Does it affect their ability to dance? _____________

Does this student have asthma? (if yes, do they carry an inhaler?)________________________

Please list any allergies (do they carry an epi-pen?)___________________________________
_______________________________________________________________________________

Please list any medical conditions this child may have (diabetes, seizure disorder, heart murmur, etc)________________________________________________________________
_______________________________________________________________________________

Is there any information we should be aware of regarding eating disorders, emotional or mental health issues?__________________________________________________________________

Are there any diet restrictions?_____________________________________________________

**Please enclose a copy of immunization records**

I have examined the aforementioned person and find him/her to be physically, mentally and emotionally capable of participation in a Eglevsky Ballet's Training Program.

Signature of Licensed Health Care Provider___________________________________Date________

Printed name______________________________________License #__________________________

Address_____________________________________________________________________________
Phone________________________

**Eglevsky Ballet**
**Medication Authorization**

700 Hicksville Road, Suite 102
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In order for medication (prescription or non-prescription) to be administered to students under age 18 during the School year, state law requires a written order from your physician indicating the frequency, dosage and any side effects of the medication. We also require the parent or legal guardian to give written consent.

Student Name___________________________ Sex_____ Date of Birth___________

Parent/Guardian signature________________________________ Date_________

Print name of parent/guardian_____________________________ Phone number____________

**TO BE COMPLETED AND SIGNED BY PHYSICIAN**

Specific diagnosis_________________________________________________________________

Name of medication_______________________________________________________________

Dosage and time__________________________________________________________________

Possible side effects_______________________________________________________________

Please circle any over the counter medication that may be taken

| Tylenol | Ibuprofen | Antacid | Anti diarrhea |
|---|---|---|---|
| Antihistamines | Cough Suppressant | Decongestant | |

Other:_____________________________

Physician's signature__________________________________ Date_________

Address__________________________________________________________________________

Telephone number____________________