STUDENT (S) HEALTH HISTORY/EMERGENCY CONTACT INFORMATION

Student Name:_____ Date of Birth:_____
Medical Conditions: (check all that apply)
Asthma___ Heart Disease___ Seizures___ Epilepsy___ Convulsions___
Hearing Impairment___ Sight Impairment___ Frequent Headaches___ Other___
Please list any allergies including insect stings:_____
Surgeries:_____
Regularly Taken Medications:_____
Are there any restrictions and/or instructions relating to student's participation?
Yes__ No__ if yes, please list_____

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EMERGENCY CONTACT INFORMATION

If a parent/guardian cannot be reached, please list below two people who can contacted to pick up your child in case of any emergency.

Contact Name:_____ Phone #:_____

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I certify that the medical information given about is accurate. If any limitations exist or arise that prevent her/his participation in VSD programs, I will notify the staff immediately. A doctor's note stating the child may resume" VIGOROUS PHYSICAL ACTIVITY" is required before a student is allowed back into class. I hereby give consent to the teachers/staff of the Voter's School of Dance to administer emergency CPR and First Aid by certified personnel and obtain medical care from any licensed physician, hospital, or clinic for any injury which may arise in the event. I/we cannot be contacted. I hereby give consent to the teachers/staff of the Voter's School of Dance to contact either of the emergency contacts listed in the case that I cannot be reached.

Parent/Guardian Name (s):_____

Signature (s):_____Date_____

PHOTO/VIDEO USE RELEASE

I give permission for images of my child to be used by VSD for promotional purposes, press releases, social media and VSD website use UNLESS OTHERWISE INSTRUCTED IN WRITING. VSD will not associate child's name with photos without seeking additional permissions.

Parent/Guardian Name (s):_____

Signature (s):_____Date_____