

MEDICAL RELAESE FORM

I, _____ (Parent/Guardian's Name) hereby give permission for any and all medical attention to be administered to my child _____ (Child's Name) in the event of accident, injury, sickness, etc. under the direction on the person(s) listed below, until such time as I may be contacted. I also assume the responsibility for the payment of any such treatment. This release is effective for the period of one year from the date given below.

HOME ADDRESS: _____

PHONE: _____

INSURANCE COMPANY: _____

POLICY NUMBER: _____

In case I cannot be reached, any of the following persons is designated to act on my behalf.

- Dawhone Perry
- New Dimensions Dance Academy

PHYSICIAN: _____

ADDRESS: _____

PHONE: _____

KNOWN ALLERGIES: _____

SIGNATURE (PARENT/GUARDIAN) _____

DATE _____

Subscribed and sworn before me _____ day of _____ 20 _____

Notary Public