

# TDEA ALL-STATE DANCE TEAM MEDICAL RELEASE FORM

TDEA  
P.O. Box 420637  
Houston, Texas 77242-0637

Mail in an original signed form & bring a copy with you to Convention!

Student Name: \_\_\_\_\_  
(Last Name) (First Name)  
Male/Female: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ School Grade: \_\_\_\_\_  
Student Cell Phone #: (\_\_\_\_\_) \_\_\_\_\_  
School Name: \_\_\_\_\_ Team Name: \_\_\_\_\_  
Director's Name: \_\_\_\_\_ Director's Cell: (\_\_\_\_\_) \_\_\_\_\_

I, \_\_\_\_\_, pledge to uphold all student policies and the high standards of the Texas Dance Educator's Association and the Texas All-State Dance Team. I understand that I am governed by the same rules on this trip as I am at school. I understand that the possession of, having used, or being under the influence of drugs, tobacco and/or alcohol is prohibited and that the school's authority to enforce policy includes: the right to inspect personal luggage, lodging accommodations, transportation vehicles, etc. I understand that any infraction will be dealt with according to school policy and may result in my being sent home immediately at my parent's expense.

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## PARENT/GUARDIAN CONSENT

I give full permission for my child to attend the Texas Dance Educator's Association Convention and participate in the Texas All-State Dance Team. I hereby release and discharge TDEA, its agents, employees, and officers from all claims, demands, actions, judgements, and executions which I may have or my child, executors, administrators, or assigns may have or claim to have against TDEA, its agents, employees, officers, volunteers, successors in interest, or assigns for all personal injuries, known or unknown, and from all known or unknown injuries to property, real or personal, cause by or arising out of the participation in the TDEA All-State Dance Team. I have read the above student agreement and understand and support the same.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent/Guardian Name (PRINTED): \_\_\_\_\_  
Address: \_\_\_\_\_  
Contact Phone #: (\_\_\_\_\_) \_\_\_\_\_ 2<sup>nd</sup> Phone #: (\_\_\_\_\_) \_\_\_\_\_

Every effort will be made to see that your child is well taken care of; however, since we must be prepared for any situation, please complete the following information:

Any Allergies: \_\_\_\_\_  
Medical History: \_\_\_\_\_  
Special Medications REQUIRED to take: \_\_\_\_\_  
When? \_\_\_\_\_ Reason for taking medication? \_\_\_\_\_  
Do we have permission to take your child to the nearest doctor or hospital should, in our opinion, the situation warrant this action? YES \_\_\_\_\_ NO \_\_\_\_\_

I, \_\_\_\_\_, give permission for my child to be treated by the physician on call and/or receive emergency care.

Name of your Family Physician: \_\_\_\_\_ Physician's Phone #: (\_\_\_\_\_) \_\_\_\_\_  
Medical Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

In case of emergency, please notify:

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_  
2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_