Dwana Smallwood
PERFORMING ARTS CENTER

Date: _____ /_____ /_____

MEDICAL RELEASE FORM

General Information

_____ _____
Student First Name **Last Name**

Date of Birth: _____/_____/_____ _____ _____ **Gender:** ☐ male ☐ female
Grade **Age**

_____ _____
Student Home # **Student Cell #**

Address: _____

_____
City **State** **Zip Code**

_____

In the event of a medical emergency, the **Dwana Smallwood Performing Arts Center, Inc.** will make every effort to contact you. In order to do so, we need emergency contact information.

Parent/ Guardian 1 _____ Home # _____ Work # _____

Parent/ Guardian 2 _____ Home # _____ Work # _____

Emergency contact _____ Home # _____ Work # _____

Medication Release

I, _____ hereby give permission to the **Dwana Smallwood Performing Arts Center, Inc.** staff to administer the following medication in age-appropriate doses to my child on an as-need basis:

	Yes	No
Tylenol/Ibuprofen	___	___
Decongestants	___	___
Antihistamines	___	___
Antacids	___	___

Parent/Guardian Signature _____ **Date** _____

Date: _____ /_____ /_____

Medical Authorization (minor)

In the event of illness or injury, I hereby consent to the right of all representatives of the **Dwana Smallwood Performing Arts Center, Inc.** to obtain on my behalf, first aid, medical care, or if necessary admission to an appropriate health care facility, including, but not limited to, anesthesia and surgery, if such care becomes necessary for the treatment of any injuries my child may sustain while at the **Dwana Smallwood Performing Arts Center, Inc**. I also hereby consent to the administration of emergency medical treatment in the event that my child is unable, because of injury, to give consent as otherwise would be necessary.

Any qualified medical personnel are hereby notified that this authorization is currently in effect as such personnel are directed to act upon such authorization without delay. I understand that reasonable efforts will be made to contact parents, the student's physician and/or emergency numbers given by me on this form

Parent/Guardian Signature _____ **Date** _____

Health Insurance Information

The following health insurance information is required in case the student is in need of medical assistance:

Name of Insurance Carrier: _____ Telephone #: (___) _____
Address: _____

_____
City State Zip Code

Name of Policyholder: _____

Type of Policy: _____ Policy number: _____

ID Number: _____

****PLEASE ATTACH A COPY OF YOUR HEALTH INSURANCE AND PRESCRIPTION PLAN (if any) CARDS**

HEALTH HISTORY
Please provide the following information below.
My child has special health needs including

Allergies	Chronic Illnesses	Medications
_____	_____	_____
_____	_____	_____
_____	_____	_____

Date: _____ /_____ /_____

Medical Report
To be completed by physician or provide a copy of the completed form supplied to student's school

In order to attend the **Dwana Smallwood Performing Arts Center, Inc.**, **annual** physicals and up to date immunization records are required. **If student records are not in compliance with New York State law, then said student will not be allowed to attend classes at the **Dwana Smallwood Performing Arts Center.** All exemptions must be approved, in writing, by the New York City Department of Health.

Immunization Records

In conjunction with the NY state law, each student is required to provide records for the following:

1. Two measles shots after their first birthday
2. One mumps, one rubella after their first birthday
3. Diphtheria/tetanus booster shot within the past 10 years
4. Tuberculin test within the past two years, if previously negative.

Are all immunizations up to date? Yes: ___ No: ___

Dance training at the Dwana Smallwood Performing Arts Center, Inc. requires each student to be able to complete and participate in a full range of physical activities.

I certify that _____ is physically able to participate in all physical activities at the **Dwana Smallwood Performing Arts Center, Inc.** ☐ Yes ☐ No

Restrictions

If there are any restrictions, please list them below.

1. _____
2. _____
3. _____
4. _____
5. _____

_____ _____
Physician Signature **Date**

_____ _____
Physician name (print) **Address**

Physician Stamp