BELHAVEN UNIVERSITY

Dance Department

CONSENT TO TREAT

I, _____, hereby give my consent to the Certified Athletic Trainer (ATC) of Belhaven University to perform services, including emergency and first aid treatment, to my person relative to injuries and illnesses that may occur during classes, rehearsals, and performances and participation in various dance events in the BU Dance Department. It is also my understanding that the ATC or providing physician has the authority to withhold me from further participation because of an injury or illness.

Print Name: _____ Student's Signature: _____

Date: _____/_____/_____ Parent/Guardian (if a minor): _____

ASSUMPTION OF RISK

I, _____, understand that there are risks of injury arising from my participation in dance. To decrease the risk of injury, I must adhere to all instructions and all rules applying to the BU Dance Department. I acknowledge that proper use of equipment, proper training, and adherence to the rules may not prevent all risks of injury, and I assume those risks. I also agree to notify the ATC of all injuries or illnesses I may incur during my participation as a BU dancer. I understand that by notifying the ATC in a timely manner of any injury or illness helps me receive proper treatment, and if I withhold this information, I may be exposing myself to potentially more damage and/or a longer recovery.

In consideration of being permitted to participate in the BU Dance Program, I hereby release BU, the Certified Athletic Trainer, dance faculty, and those volunteering in the course of my medical care from all liability and responsibility for any loss or injury related to my participation in the BU Dance program. I further agree to indemnify and hold harmless said parties from all claims hereafter made by me or on my behalf by my parents, guardians, or assigns.

Print Name:_____ Student's Signature: _____

Date: _____/_____/_____ Parent/Guardian (if a minor): _____

MEDICAL INFORMATION RELEASE FORM

I, _____, hereby authorize and consent to the release of any pertinent medical information and records regarding the treatment, diagnoses, and/or examination relative to injuries or illnesses that may affect my participation in BU Dance Program to the ATC and/or dance faculty as is necessary for the appropriate treatment of those injuries/illnesses. Medical information may also be released to my parents/legal guardians. I also acknowledge that certain details of my injuries or illnesses may be used in the Dance Medicine education programs in the Dance Department as long as these facts are not personally identifiable as related to me. I understand that I can revoke this authorization at anytime in writing to the BU Dance Department. Unless I exercise my right to revoke this authorization, this said release will be in effect for the duration of my participation in dance at BU, beginning with the date below.

Print Name: _____ Student's Signature: _____

Date: _____/_____/_____ Parent/Guardian (if a minor): _____