

Angela Bates Dance Academy Waiver and Consent Form

Student Name: _____ Birthdate: _____ Age: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Are there any health concerns or allergies the studio and staff should be aware of?

No Yes

If yes, please explain:

Mother's Name: _____ Father's Name: _____

Mother's Cell: _____ Mother's Email: _____

Father's Cell: _____ Father's Email: _____

Student's Cell: _____ Students Email: _____

Other Contact Info: _____

Emergency Names and Contacts: _____

I, the undersigned, hereby acknowledge that certain risks of injury are inherent to participation in these dance related physical activities. These risks and dangers may be other caused by the action, inaction or negligence of the participant and others. There may be other risks not know or reasonably foreseeable at this time. I accept and assume such risks and responsibility for the loses and/or damages following such injury, however caused, and whether caused in whole or in part by the negligence of the named student above. If the student has a temporary restriction (sickness, sprain, soreness, etc.) I will inform the appropriate instructor on a daily basis in writing. I agree that the student and I will abide by the rules of the Angela Bates Dance Academy ("ABDA"). I consent to the student's participation in ABDA physical programs, classes and activities. Recognizing the possibility of physical injury associated with these programs, classes and activities, and in consideration for ABDA accepting the student for its programs, classes and activities, I hereby release, discharge, indemnify, and hold harmless ABDA, its affiliated organizations, and their employees, teachers/subcontractors and associated personnel from and against any and all claims by or on behalf of the student as a result of the student's participation in the programs, classes and activities. In my absence, I also request ABDA, through its staff, to obtain emergency medical care in the event that such care is necessary or appropriate in the opinion of the staff for the benefit of the student due to accident or illness. I agree to pay any treatment costs directly to the hospital, physician, or laboratory providing such care upon presentation of the bill to me.

Parent/Guardian Signature: _____ Date: _____

Student Signature: _____ Date: _____

Photo Release - I, the undersigned, give permission for ABDA and their staff to photograph the above named student during classes or performances to be used for studio displays and promotional material such as all forms of social media.

- Yes, I give ABDA and their staff permission to photograph the above named student.
 No, I do NOT give ABDA and their staff permission to photograph the above named student.

Video Release - I, the undersigned, give permission for ABDA to video the above named student during classes and performances to be used for studio displays and promotional material such as all forms of social media.

- Yes, I give ABDA and their staff permission to video the above named student.
 No, I do NOT give ABDA and their staff permission to video the above named student.