TDEA ALL STATE DANCE TEAM
MEDICAL RELEASE FORM

BRING A COPY WITH YOU TO CONVENTION!

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

STUDENT'S NAME: _____
(Last Name) (First Name)
MALE/FEMALE: _____ BIRTHDATE: _____ AGE: _____ SCHOOL GRADE: _____
STUDENT CELL PHONE #: _____
SCHOOL NAME: _____ TEAM NAME: _____
DIRECTOR'S NAME DIRECTOR 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 POSSESSION OF, HAVING USED, OR BEING UNDER THE INFLUENCE OF DRUGS 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: _____

PARENTAL / 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 AGREE NOT TO HOLD THE TDEA, ITS MEMBERS, OR APPOINTED CHAPERONES RESPONSIBLE FOR ANY ACCIDENT OR MISHAP WHILE ON THE TRIP. I HAVE READ THE ABOVE STUDENT PLEDGE AND UNDERSTAND AND SUPPORT THE SAME.

PARENT SIGNATURE: _____ DATE: _____
ADDRESS: _____
PHONE ( ) - _____ 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:
ALLERGIES: _____
MEDICAL HISTORY: _____
SPECIAL MEDICATIONS REQUIRED TO TAKE: _____
WHEN?: _____ WHAT FOR?: _____

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.

WHO IS YOUR FAMILY PHYSICIAN? _____ PHYSICIAN'S PHONE_____
INSURANCE COMPANY: _____ POLICY NUMBER:_____

IN CASE OF EMERGENCY, NOTIFY:
1._____ PHONE: _____
2._____ PHONE: _____