(Please Print)

Colorado Ballet Society Medical Waiver

Student Name: _____Parent Name: _____

I agree and understand that Colorado Ballet Society Inc., staff and faculty are not held responsible for any injuries occurring on the premises at any time**.** My child carries/I carry emergency medication by the name of _____ to be used for _____. My child **is/is not** (circle one) able to self-administer this medication if in an appropriate medical state to do so. If the student is unable to utilize the device him/herself, Colorado Ballet Society staff, acting under Good Samaritan laws, will administer the medication to the best of our abilities. Staff are not trained medical professionals. In order to assist in this way, we need to have the medication and know how to administer. **Please provide any additional information on a separate page.**

Insurance Company: _____ Policy Number: _____

Physician: _____ Phone Number: _____

Please list the following below and initial each line. Continue on separate page as needed.
If none, you must write "none" and initial on each line. Thank you.

Allergies: _____ Initial if none: _____

Medical Conditions: _____Initial if none: _____

Physical Restrictions, Injury, and Surgery History: _____Initial if none: _____

Learning Needs: (Ex: processing delay, glasses, reduced hearing, IFSP/IEP, highly concrete thinker, etc.). :_____

_____Initial if none: _____

Sensory and Cultural Needs (Ex: language spoken, sensory defensiveness, PTSD, etc.): _____

_____Initial if none: _____

Signature: _____ Date:_____

(Please Print)

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