

Liability Wavier

Please print off a copy of this document. This Liability Waiver, Media Consent Form, and the Health Information of the student must be handed in prior to starting a class. Please provide a completed form for each individual student.

Name of Dancer: _____ Age: _____

Birth Date: _____ / _____ / _____

Address: _____

City: _____ Province: _____

Phone: _____ Email: _____

Emergency Contact Name: _____

Emergency Phone: _____

Liability Waiver:

The student _____ (or if under 18 years old the parent/legal guardian) understands that dance and/or Zumba includes physical movement as well as many other positive factors. As in the case with any physical activity the risk of injury, even serious or disabling, is always present and cannot be eliminated. If the student experiences any pain or discomfort, they will listen to their body, discontinue the activity, and ask for support from the instructor(s). The student will assume full responsibility for all injury, which may occur with participation. By signing, the student has been verified to participate in such fitness, with their health and medical conditions being considered. They will make the instructor(s) aware of any medical conditions or physical limitations before class. I hereby agree to irrevocably reveal and wave any claims that I have now or may have hereafter against Flourish Dance Studios and its instructors/owners.

I have read and fully understand and agree to the above terms of this Liability Waiver Agreement. I am signing this agreement voluntarily and recognize that my signature serves as complete and unconditional release of all liability.

Student (Printed): _____
(OR if under 18 years old)

Parent/Legal Guardian (Printed): _____

Signature: _____

Date: Birth Date: _____ / _____ / _____

Media Release Form:

During the dance season, your child may be photographed/videoed. With your consent, the content may be released for the use of newspapers, brochures, videos, our website, social media accounts for the studio, etc.

Please indicate your preference below.

- YES Photographs/videos of my child may be released for use in the media.

- NO Photographs/videos of my child may not be released for use in the media.

Health Information:

All information will remain confidential and only to be shared with staff who will be working with your child or yourself for safety reasons if it is applicable. Please share what is necessary for us to be aware of or you feel is important to document.

List of medications:

Allergies: *Please include name/type of allergy, reactions, and treatment below.*

Health History: (Please check conditions your child has or has had)

- ADD/ADHD
- Arthritis/Joint Issues
- Asthma
- Blood disorders
- Bowel/bladder problems
- Developmental delays
- Diabetes __ T1 __ T2
- Fainting/dizziness
- Hearing impairment
- Heart condition
- Hepatitis/HIV
- Hospitalizations
- Learning disability
- Menstrual problems
- Mental health condition
- Migraines
- Physical limitations
- Seizures, tics, or tremors
- Serious illness: _____
- Visual impairment
- Other: _____
- Any previous injury? _____