



**LIABILITY WAIVER SUMMER INTENSIVE 2020**

PLEASE PRINT ALL INFORMATION CLEARLY and return to Kentucky Ballet Theatre by April 17, 2020. Your parent or guardian must sign if you are under 18. All signatures are required for your admission to Kentucky Ballet Theatre Summer Program.

A COPY OF THE FRONT & BACK OF YOUR HEALTH INSURANCE CARD MUST BE INCLUDED WITH THIS FORM (One sheet of one-sided 8.5x11 paper). BE SURE YOUR HEALTH INSURANCE POLICY PROVIDES FOR OUT OF TOWN ROUTINE AND EMERGENCY CARE. IF NOT, YOU MUST TAKE OUT A TEMPORARY RIDER.

STUDENT FIRST NAME \_\_\_\_\_ LAST NAME \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ AGE BY JUNE 1, 2020 \_\_\_\_\_

EMERGENCY CONTACT (*parents/guardian*) \_\_\_\_\_

TELEPHONE: Day (\_\_\_\_) \_\_\_\_\_ Evening (\_\_\_\_) \_\_\_\_\_

Alternate (Cell, etc.) (\_\_\_\_) \_\_\_\_\_

ALTERNATE EMERGENCY \_\_\_\_\_ TELEPHONE (\_\_\_\_) \_\_\_\_\_

HEALTH INSURANCE CARRIER \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_

STATE \_\_\_\_\_ ZIP \_\_\_\_\_

POLICY HOLDER \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

NAME OF EMPLOYER \_\_\_\_\_

EFFECTIVE DATE OF INSURANCE \_\_\_\_\_

COMPLETE ADDRESS OF EMPLOYER \_\_\_\_\_

CIRCLE: Full-Time Part-Time

PHONE NUMBER OF EMPLOYER (\_\_\_\_) \_\_\_\_\_

POLICY # \_\_\_\_\_

MEDICAL RELEASE / LIABILITY WAIVER- I, the undersigned, hereby consent to medical care and treatment as deemed necessary and proper by the medical staff of University of Kentucky Hospital for the student identified above. I understand that the patient is under the direct care of physicians while in the Hospital and I expect the Hospital to carry out their instructions. Therefore, this signed consent includes my consent for any hospital services rendered under the general or special instructions of a physician, including, but not limited to x-ray examinations, laboratory procedures, medical or surgical treatments, and administration of anesthesia. I also understand that the physicians are independent contractors and not employees of the Hospital. I acknowledge that any medical care furnished the patient in the Emergency Department will be limited solely to emergency treatment. I understand that the patient may be released before all patient's medical problems are known or treated, and that it will be necessary for the patient to arrange follow-up care.

The undersigned, hereby releases, discharges and forever acquits the Kentucky Ballet Theatre, its respective agents, affiliates, directors and employees of any and all liability, claims, demands, actions and causes of action whatsoever, arising out of or related to any loss, damage or injury, including death, that may be sustained by the undersigned or any participant in, person at, or to the property of the undersigned while either participating in or being present at the Kentucky Ballet Theatre, including, but not limited to, those injuries and damages caused by negligence whether it be active or passive, wanton, or ordinary on the part of the Kentucky Ballet Theatre, and its respective agents, affiliates, directors and employees arising from the undersigned while participating in or being present at the Kentucky Ballet Theatre. This release shall be binding upon the assignees, distributees, heirs, next of kin, executors and administrators of the undersigned and may be pled by the Kentucky Ballet Theatre in any complete bar and defense against any claim, demand, action or cause of action by or on behalf of the undersigned.

I will be contacted in the event of medical emergency. If I cannot be contacted, I hereby authorize the Kentucky Ballet Theatre to then contact the above listed alternate emergency contact. In the event the undersigned parent/guardian cannot be contacted, nor the alternate emergency contact, I give permission to the Kentucky Ballet Theatre, or their appointed representative, to recommend a medical professional and sign for care. In the event of a non-emergency medical problem, the Kentucky Ballet Theatre may recommend a medical professional to secure proper treatment. Selection and visitation of a medical professional for treatment will be my decision.

I hereby give permission to allow my child to engage in all assigned activities, to participate in physical therapy screening, strengthening and rehabilitating exercises that may be given in lectures and class sessions by the University of Kentucky Physicians and physical therapists. I also give my permission, that undersigned student may use weight machines and other equipment at the Kentucky Ballet Theatre or at the Clarion Hotel.

I also give permission to photocopy the Physicians Report for medical use and for the housing staff to have readily available for any non-emergency or emergency situations.

By execution of this release, the undersigned hereby acknowledges and expressly represents that:

\_\_\_ he/she is duly aware of the risks and hazards inherent upon entering the Kentucky Ballet Theatre,

\_\_\_ he/she elects voluntarily to enter, participate or be present at the Kentucky Ballet Theatre,

\_\_\_ he/she has read the foregoing release, understands it and signs it voluntarily, and

\_\_\_ his/her parent or legal guardian, who is at least 18 years of age, and of sound mind, has read the foregoing release, understands it and signs it voluntarily.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian, Printed \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**Return this form Kentucky Ballet Theatre, Registrar, 740 National Ave., Ste 170 Lexington, KY 40502  
FAX 859.252.7925 \* EMAIL: admin@kyballet.com**