

THE PERFORMERS
BALLET & JAZZ
 COMPANY

AUTHORIZATION FOR MEDICAL TREATMENT AND LIABILITY RELEASE

I hereby designate The Performers Ballet & Jazz Company, its Board of Directors, its agents or _____ (at your option insert name of designated person) to act in my/our behalf to authorize any hospitalization, medical treatment or care, surgery or any other health care services that may be recommended in an emergency because of illness or injury sustained by my minor child while participating in conjunction with The Performers Ballet & Jazz Company activities where I/we are physically incapacitated, unavailable, unreachable, not present, or otherwise legally incapacitated.

I/we agree to assume all financial responsibility for any and all health care services provided pursuant to this Authorization. I/we understand that The Performers Ballet & Jazz Company will try to contact me/us within a reasonable amount of time under the totality of the circumstances in the event of illness, injury, accident to my minor child that requires health care services. I/we agree to assume, as an explicit condition of my minor child's participation, any and all risks arising from this Authorization, including but not limited to negligent medical care provided pursuant to this Authorization. However this Authorization is not intended to release any medical care provider from any liability as a third-party beneficiary or otherwise.

I/we hereby agree as an explicit condition of my/our minor child's participation that I/we will not hold The Performers Ballet & Jazz Company, its Board of Directors, and its agents liable from any and all claims, demands, causes of action or lawsuits arising from the use of this Authorization.

Name of Minor Child: _____

I am the parent or guardian of the minor named above and I have the legal authority to execute the above release. I approve the foregoing and waive any rights in the premises.

Signed: _____ **Date:** _____, 2012
 Parent or Guardian

Signed: _____ **Date:** _____, 2012
 Parent or Guardian

Address: _____

Phone Numbers: _____

Name of Medical Insurer: _____ (Attach copy of card)

Alternate Emergency Contacts:

Name: _____ Number(s): _____

Name: _____ Number(s): _____

PO BOX 21717, ALBUQUERQUE, NM, 87154-1717 (505) 292-5800

The Performers is a non-profit 501(c)3 organization