



MEDICAL FORM

135 Daniel Street
Portsmouth, NH 03801
Tel. 603-430-9309

HEALTH HISTORY

Student's Name: _____ Date of Birth: _____ Age: _____

Allergies (including insect stings): _____

Asthma: _____ Heart Disease: _____ Diabetes: _____ Hearing Impairment: _____

Convulsions: _____ Seizures: _____ Epilepsy: _____ Sight Impairment: _____

Frequent Headaches or Ear Infections: _____ Other: _____

Operations: _____

Regularly Taken Medications: _____

Are there any restrictions and/or instructions to the student's participation in BNE/CDE programs? _____

If yes, please explain: _____

I certify that the medical information given above is accurate. If any limitations exist or arise that would prevent his/her participation in BNE CDE programs, I will notify the staff immediately. Removal from participating in the program may be required until such time that corrective action is take to allow the child to resume participation. A doctor's note stating the child may resume "VIGOROUS PHYSICAL ACTIVITY" is required before the student is allowed to resume classes.

Signature of parent/legal guardian: _____ Date: _____

INSURANCE INFORMATION AND RELEASE FOR EMERGENCY MEDICAL TREATMENT

Name of Insurance Company Child is Covered By: _____

Address: _____ Policy Number: _____

Policy Holder Name: _____ Relationship to Child: _____

This is to certify that as the child's parent or legal guardian, I/we hereby give our consent to the teachers and staff of Ballet New England Center for Dance Education to administer emergency CPR and First Aid by certified personnel and obtain medical care from any licensed physician, hospital, or clinic for any injury that may arise.

Signature of parent/legal guardian: _____ Date: _____

**THIS FORM SHOULD BE UPDATED ANNUALLY
PLEASE NOTIFY BNE IF ANY OF THIS INFORMATION CHANGES**