FLYING GRAVITY CIRCUS

HEALTH, EMERGENCY AND MEDIA RELEASE FORM 2017

FLYING GRAVITY CIRCUS Programs include but are not limited to: Blue Troupe, Green Troupe, Pre-Troupe, Open Training, Summer Tour, Aerials Classes, Adult Classes, Private Lessons, Circus After School Program, Circus Workshops, Circus Residencies, and the Silver Lining Circus Camp.

THIS FORM MUST BE COMPLETED IN FULL AND RETURNED TO FLYING GRAVITY CIRCUS PRIOR TO THE FIRST DAY OF PROGRAM.

Participant Information

Participant's Name: _____ Age _____

Nick Name: _____ (Circle) Male Female

Current Grade: _____ Birth date: _____

Home Address: _____

Town: _____ State: _____ Zip: _____

School Attended: _____

Parent Information

First Parent's Name: _____ Cell # : _____ Home #: _____

Place of Work: _____ Work Phone #: _____

Email: _____

Second Parent's Name:_____ Cell # : _____ Home #: _____

Place of Work: _____ Work Phone #: _____

Email: _____

If parents are unavailable in an emergency, please notify:

Name: _____ Relation: _____ Phone #: _____

Name: _____ Relation: _____ Phone #: _____

Health History (Answer and give approximate dates)

Has your child ever required hospitalization?

_____

Operations or serious injuries (list dates)?

_____

Disability or chronic/recurring illness?

_____

Dietary modifications or allergies?

_____

Epipen or inhaler needed (please bring to program)? _____

Date of last physical _____

Any specific activities that your child cannot participate in?

_____

Additional information you think we should know:

Participant's Name: _____

Doctor / Insurance Information
Name of Family/Child Physician: _____ Phone #: _____

Name of medical insurance _____ Policy/group # _____

Name & Address of preferred emergency facility/hospital _____

_____

This health history is correct as far as I know and the person listed above has permission to engage in all prescribed FLYING GRAVITY CIRCUS activities except as noted. In the event I cannot be reached in an emergency, I hereby give permission to the FLYING GRAVITY CIRCUS STAFF to secure proper treatment for the person named above. I expect to be notified immediately.

Parent/Guardian Signature _____ Date: _____

Permission for Pick Up
Please write in any persons you authorize to pick up your child/teen from program. If a name is not listed below, staff will not release your child to that person. Please make every effort to list people that may be picking up your child during the program, including YOURSELF, grandparents, siblings, friends, etc. Use a separate piece of paper if necessary.

Name	Phone Number	Relation

Parent permission to film and/or photograph
I give FLYING GRAVITY CIRCUS permission to take and reproduce photographs, video, and/or other recordings of my child/teen while he/she is participating in any FLYING GRAVITY CIRCUS program. I give FLYING GRAVITY CIRCUS permission to include my child/teen's name, age and town of residence along with photographs and/or video and/or other recordings, and to provide this information to the media. I agree that FLYING GRAVITY CIRCUS shall have exclusive rights to use, and to authorize others to use the material resulting from said photographs and/or video and/or other recordings in any way FLYING GRAVITY CIRCUS wishes, including but not limited to using it on publicity materials including the FLYING GRAVITY CIRCUS website, advertising, films, interviews, documentaries books, television productions, and brochures, in print and/or electronic media including facebook, and sometimes in presentations by our staff for educational purposes.

Parent/Guardian Signature _____ Date: _____

MEDICATIONS:

THE FOLLOWING IS A LIST OF MEDICATIONS THAT FLYING GRAVITY CIRCUS STAFF MAY HAVE ON SITE (NOT GUARANTEED) AND MAY HAVE AVAILABLE TO ADMINISTER TO YOUR CHILD IF A NEED ARISES. PLEASE CHECK THE BOX NEXT TO ANY MEDICATION THAT YOU DO GIVE PERMISSION FOR FLYING GRAVITY CIRCUS STAFF TO ADMINISTER, OR INDICATE ANY ALLERGIES OR PREFERENCE NOT TO ADMINISTER.

Drug/Remedy	Route	Dosage: as recommended on medication.	Please indicate whether you GIVE PERMISSION for FLYING GRAVITY CIRCUS Staff to administer this medication, or reason / preference NOT TO ADMINISTER.	Parent or Guardian Initials
Arnica	Topical			
Tylenol	Oral			
Advil and/or Ibuprofen	Oral			
Benadryl	Oral			
Neosporin	Topical			
Calendula	Topical			
Badger Balm Muscle Rub	Topical			

PLEASE FILL OUT THE FOLLOWING IF YOUR CHILD REQUIRES ANY MEDICATIONS BE TAKEN DURING PROGRAM.

Participant's Name: _____DOB: _____Weight:_____

Drug	Route (orally, topically)	Dosage	Schedule and Indications	Comments/ Side Effects	Parent or Guardian Initials

***All medications must be in their original container when submitted to the program director.**

I hereby authorize FLYING GRAVITY CIRCUS staff to administer the medication(s) initialed above to my child/teen as indicated. I understand that there is no physician on site at FLYING GRAVITY CIRCUS programs.

Parent/Guardian Signature _____ Date: _____