KEVIN JONES
PERFORMING ARTS
S·T·U·D·I·O

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New York City Adult Trip 2009

PERMISSION FORM

I, ______________________________ hereby agree to participate as a traveler with the Kevin Jones Performing Arts Studio Performing Arts trip to New York City (February 12-15, 2009).

In consideration, I hereby waive and release all rights and claims for damages against Kevin Jones, Kevin Jones Performing Arts Studio, its agents, associates, volunteers and employees. This waiver includes (but is not limited to) release from all actions, causes of action, damages, claims or demands which I, my heirs, executors, administrators or assigns may have against Kevin Jones, Kevin Jones Performing Arts Studios, and/or other above described parties and associates for all personal injuries (known or unknown), which the above named child has or may incur from illness, accident, or travel.

I allow Kevin Jones Performing Arts Studio to use photographs, videotapes, and recordings made during the trip, including letters written to Kevin Jones Performing Arts Studio (and or its agents, volunteers, and/or employees) during or after the trip for promotional purposes.

Furthermore, I authorize representatives and/or associates of Kevin Jones Performing Arts Studio to seek medical care for me in case of emergency during the course of the trip (February 12-15, 2009). I release Kevin Jones Performing Arts Studio and/or its representatives and associates from liability arising from such care.

The undersigned has read the foregoing and understands all its terms. It is executed voluntarily and with full knowledge of its significance.

______________________________ __________

Participant Name (Signature) **Date**

(OVER~)

CONTACT INFORMATION

PARTICIPANT'S NAME______________________________ BIRTH DATE_____________

HOME PHONE________________ CELL PHONE__________________

HOME ADDRESS____

IN AN EMERGENCY PLEASE NOTIFY:

Name_____________________________ Phone____________________

HEALTH HISTORY

ALLERGIES:

To Medications (please list)
____

Hay Fever _______ Trees/Grass ________ Insect Stings________ Other_____________

IMMUNIZATIONS: Date of Last Tetanus Booster ____________

HISTORY OF ILLNESS AND/OR INJURY:

Convulsions Yes_____ No_____ Heart Defect or Disease Yes_____ No_____
Bleeding Disorder Yes_____ No_____ Diabetes Yes_____ No_____
Asthma Yes_____ No_____ Kidney Disease Yes_____ No_____

Operations, serious injuries, or other diseases (please include dates)________________________
____

PLEASE LIST ALL MEDICATIONS FREQUENTLY TAKEN:
____
____

Name of family physician ________________________ Phone_______________

Name of dentist_______________________________ Phone_________________

Insurance Company_________________________________

Policy Number__________________ Group Number__________________