

**APPLICATION FOR PARTICIPATION IN THE
FOSTER SCHMIDT DANCE ACADEMY**

NAME: _____ AGE: _____

GENDER: _____ T-SHIRT SIZE(adult or child): _____

ADDRESS: _____

CITY: _____ EMAIL : _____

STATE: _____ ZIP: _____ HOME PHONE: _____

PARENT/GUARDIAN NAME: _____

PARENT/GUARDIAN ADDRESS: _____

CITY: _____

STATE: _____ ZIP: _____ HOME PHONE: _____

EMERGENCY CONTACT PERSON: _____

EMERGENCY CONTACT PHONE: _____

HEALTH INSURANCE COMPANY: _____

MEDICAID: _____

HEALTH HISTORY

	YES	NO		YES	NO
1. Heart disease/heart defect/high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	13. Special diet	<input type="checkbox"/>	<input type="checkbox"/>
2. Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	14. Asthma	<input type="checkbox"/>	<input type="checkbox"/>
3. Seizures/epilepsy/fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	15. Easy bleeding	<input type="checkbox"/>	<input type="checkbox"/>
4. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	16. Emotional/behavioral	<input type="checkbox"/>	<input type="checkbox"/>
5. Concussion or serious head injury	<input type="checkbox"/>	<input type="checkbox"/>	17. Sickle cell trait	<input type="checkbox"/>	<input type="checkbox"/>
6. Major surgery or illness	<input type="checkbox"/>	<input type="checkbox"/>	18. Allergy: _____		
7. Heat stroke/exhaustion	<input type="checkbox"/>	<input type="checkbox"/>	19. Immunization up to date	<input type="checkbox"/>	<input type="checkbox"/>
8. Blindness/visual problems	<input type="checkbox"/>	<input type="checkbox"/>	20. Date of last tetanus shot: _____		
9. Contact lenses/glasses	<input type="checkbox"/>	<input type="checkbox"/>	Please print medication name, amount, date		
10. Hearing loss/hearing aid	<input type="checkbox"/>	<input type="checkbox"/>	prescribed and number of times per day		
11. Bone or joint problems	<input type="checkbox"/>	<input type="checkbox"/>	medication is given.		
12. Special diet	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Please describe:			_____		
_____			_____		

Signature of Person completing form: _____ Date: _____

**ATLANTO-AXIAL INSTABILITY ASSESSMENT
FOR ATHLETES WITH DOWN SYNDROME**

PLEASE NOTE: All children and young adults with Down syndrome are required to have a full radiological examination establishing the absence of Atlanto-Axial Instability before she/he may participate in sports or events which by their very nature, may result in hyperextension, radical flexion or direct pressure on neck or upper spine.

	YES	NO	
Has x-ray evaluation for atlanto-axial instability been done?	<input type="checkbox"/>	<input type="checkbox"/>	Date of x-ray: _____
If yes, was it POSITIVE for atlanto-axial instability	<input type="checkbox"/>	<input type="checkbox"/>	_____

PHYSICAL EXAMINATION

Blood Pressure: _____/_____ Weight: _____ Height: _____

	Normal	Abnormal		Normal	Abnormal		Normal	Abnormal
Vision	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular System	<input type="checkbox"/>	<input type="checkbox"/>	Cranial Nerves	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory System	<input type="checkbox"/>	<input type="checkbox"/>	Coordination	<input type="checkbox"/>	<input type="checkbox"/>
Oral Cavity	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal System	<input type="checkbox"/>	<input type="checkbox"/>	Reflexes	<input type="checkbox"/>	<input type="checkbox"/>
Neck	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary System	<input type="checkbox"/>	<input type="checkbox"/>			
Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>			

When this form, and the release that follows, is completed please send along with a check for \$30.00 made payable to "JSTA", to the following address:

**JSTA
521 Summer Terrace Lane
Atlanta, GA 30342**

If for any reason the fee of \$30.00 would inhibit your child/young adult from participating, please include on a separate sheet of paper your request for scholarship opportunities for the FOSTER-SCHMIDT DANCE ACADEMY

RELEASE TO BE COMPLETED BY ADULT ATHLETE

I, _____, am at least 18 years old and have submitted the attached application for participation in the *FOSTER-SCHMIDT DANCE ACADEMY*.

I represent and warrant that, to the best of my knowledge and belief, I am physically and mentally able to participate in *FOSTER-SCHMIDT DANCE ACADEMY* activities. I also represent that a licensed physician has reviewed the health information contained in my application and has certified, based on an independent medical examination, that there is no medical evidence which would preclude me from participating in the *FOSTER-SCHMIDT DANCE ACADEMY*.

The *FOSTER-SCHMIDT DANCE ACADEMY* has my permission (both during and anytime after), to use my likeness, name, voice or words in either television, radio, film, newspaper, magazines and other media, and in any form, for the purpose of advertising or communicating the purpose and activities of the *FOSTER-SCHMIDT DANCE ACADEMY* and/or applying for funds to support these purposes and activities.

If, during my participation in *FOSTER-SCHMIDT DANCE ACADEMY* activities, I should need emergency medical treatment, and I am not able to give my consent or make my own arrangements for that treatment because of my injuries, I authorize the *FOSTER-SCHMIDT DANCE ACADEMY* to take whatever measures necessary to protect my health and well-being, including if necessary hospitalization.

I, the athlete named above, have read this paper and fully understand the provisions of the release that I am signing. I understand that by signing this paper I am saying that I agree with the provisions of this release.

Signature of the adult athlete: _____ Date: _____

I hereby certify that I have reviewed this release with the athlete whose signature appears above. I am satisfied based on that review that the athlete understands this release and has agreed to its terms.

Name: _____ Date: _____

Relationship to athlete: _____

RELEASE TO BE COMPLETED BY PARENT OR GUARDIAN OF MINOR ATHLETE

I am the parent/guardian of _____, the minor athlete, on whose behalf I have submitted the attached application for participation in the *FOSTER-SCHMIDT DANCE ACADEMY*. I hereby represent that the athlete has my permission to participate in *FOSTER-SCHMIDT DANCE ACADEMY* activities.

I further represent and warrant that, to the best of my knowledge and belief, the athlete is physically and mentally able to participate in *JENSEN-SCHMIDT TENNIS ACADEMY* activities. With my approval, a licensed physician has reviewed the health information set forth in the athlete's application and has certified, based on an independent medical examination, that there is no medical evidence which would preclude the athlete from participating in the *FOSTER-SCHMIDT DANCE ACADEMY*.

In permitting the athlete to participate in the *FOSTER-SCHMIDT DANCE ACADEMY*, I am specifically granting my permission (both during and anytime after), to use the athlete's likeness, name, voice or words in either television, radio, film, newspaper, magazines and other media, and in any form, for the purpose of advertising or communicating the purpose and activities of the *FOSTER-SCHMIDT DANCE ACADEMY* and/or applying for funds to support these purposes and activities.

If, during the athlete's participation in *FOSTER-SCHMIDT DANCE ACADEMY* activities, and she/he should need emergency medical treatment, and I am not personally present to give my consent or make arrangements for that treatment, I authorize the *FOSTER-SCHMIDT DANCE ACADEMY* to take whatever measures necessary to protect the athlete's health and well-being, including if necessary hospitalization. I am the parent (guardian) of the athlete named in this application. I have read and fully understand the provisions of the above release, and have explained these provisions to the athlete. Through my signature on this application, I am agreeing to the above provisions on my own behalf and on the behalf of the athlete named above.

I hereby give my permission for the athlete named above to participate in the *FOSTER-SCHMIDT DANCE ACADEMY*.

Signature of parent/guardian: _____ Date: _____