

TRIPLE THREAT PRODUCTIONS

Medical Clearance Form

DANCER NAME - _____

I, hereby provide my signature below, do certify that I am licensed by the state and am qualified in determining that: Dancer's Name: _____ is physically fit and I have found no medical or observable conditions which would contra-indicate him/her from participating on the Triple Threat Productions Dance Team. I am therefore clearing this individual for dance participation.

Please Print - or - Use Office Stamp Here:

Signature:

Print Name Clearly:

Date: _____ / _____ / _____

Office Address: _____

PLEASE NOTE: If this Medical Clearance is voided by injury, accident, or illness, it will be the responsibility of the dancer to notify Triple Threat Productions and to also to obtain WRITTEN permission from his/her physician to resume participation. A "Doctors Resume Participation Medical Clearance Form" is available from Triple Threat Production or you may have the doctor supply his/her own WRITTEN Clearance as long as it is on the doctor's official stationary and includes the following statement: "(Participants Name) is physically fit and I have found no medical or observable conditions which would contra-indicate him/her from participating on the Triple Threat Productions Dance Team. I am therefore clearing this individual for dance participation.

This statement must be supplied by the physician attending to the injury, accident, or illness.

This form can be modified or substituted ONLY to comply with local and/or state laws or due to medical practitioner regulations.

NOTE: This form as with any and all forms used by Triple Threat Productions and is reviewed by our counsel for compliance with any state or local statutes. This form will be kept on file for a minimum of 7 years, longer in the event of an injury. Please confer with your local attorney for advice as to the appropriate maintenance and storage term for this and all such forms.