Junior TRAINING PROGRAM
BROADWAYDANCECENTER

BROADWAY DANCE CENTER
NEW YORK CITY®
Inspiring the World to Dance

COMPULSORY HEALTH FORM

This health form must be signed by a physician and stamped with an official stamp.
This form is a confidential document solely between the student and BDC.

TODAY'S DATE: _____ COURSE START DATE: _____ LENGTH OF COURSE: _____

LAST NAME: _____ FIRST NAME: _____ NICK NAME: _____

☐ MALE ☐ FEMALE (check one) DATE OF BIRTH: _____ *Please write out-date month year (ex. 18 April 1982)*

PARENT'S NAME: _____ PARENT'S PHONE NUMBER: _____

IN CAE OF EMERGENCY NOTIFY: _____

PHONE NUMBER AND EMAIL: _____

RELATIONSHIP TO STUDENT: _____

MEDICAL HISTORY

1. Please list any medical conditions you have:
may include asthma, allergies, diabetes, heart conditions, high or low blood pressure etc.

_____

_____

2. List all medications that you take. We recommend that you bring what you may need or a written prescription from your physician.

NON-PRESCRIPTION: _____

PRESCRIPTION: _____

3. List any allergies or reactions you have had to medications.

MEDICATION	REACTION	DATE

4. List any allergies or reactions you have to foods, molds, pollens, bees, insects, animals etc.

_____

_____

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5. List any physical or dance related problems you have including injuries, bone, joint, or muscular disorders, etc.

_____

_____

6. Have you ever been hospitalized? ☐ YES ☐ NO
(If yes, please specify below including dates)
PHYSICAL ILLNESS: _____

INJURY: _____

SURGERY: _____

PSYCHIATRIC: _____

7. Have you been diagnosed with mental health issues, severe stress, mood change, or personality disorder BDC should be aware of?

_____

_____

8. Have you been vaccinated for the following: ☐ Chicken Pox ☐ Measles ☐ Mumps

9. Please list all doctors' information below, including primary care physician, chiropractors, physical therapists, etc.

PRIMARY PHYSICIAN _____ TELEPHONE _____

OTHER HEALTHCARE PROVIDERS _____ TELEPHONE _____

10. Student Declaration

I, _____ confirm that the information provided on this form is correct and true.

Student's signature _____ Date _____

11. Doctor's Statement

I, _____ confirm that _____ is physically and mentally fit to participate in 18 hours of dance per week whilst studying at Broadway Dance Center. I confirm that the above information listed in this health form is true and correct.

Doctor's Signature (required) _____ Date _____ Doctor's Official Stamp _____

Doctor's Address _____ Telephone Number _____ Email _____

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