



# DANCE DAY

January 22, 2012 • perform at  
halftime of UK Hoops game • 2 pm  
\$35.00/participant

**CALLING ALL DANCERS & PEOPLE WHO LOVE TO DANCE!! Ages 4 years and older.**

UK Dance Day will be Jan. 22, 2012 at half-time of the UK Hoops vs Florida Game.

We will teach a routine on Jan. 21 (6-9pm Memorial Coliseum) and perform in various age groups.

We want young kids, older kids, adults, and seasoned adults to come out and shake their groove thing!!!

**Each dancer will receive a Dance Day t-shirt, and a free ticket for themselves and a guest to the game.**

## REGISTRATION FORM

Please complete and return with payment. Applications will be processed on a first-come, first-served basis.

**Online registration available at [UKathletics.com](http://UKathletics.com). Follow camp links.**

Name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

Home Address \_\_\_\_\_ City, State \_\_\_\_\_ Zip Code \_\_\_\_\_

Email Address \_\_\_\_\_ Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

T-shirt size (please check one):  Youth M  Youth L  Adult S  Adult M  Adult L  Adult XL

Please make checks payable to: UK Dance Day • Mail to: UK Dance Day, Accounting Office, Joe Craft Center, 338 Lexington Avenue, Lexington, KY 40506-0604

**To register or pay with a credit card please go to: [UKathletics.com](http://UKathletics.com) and follow the camps link**

### Insurance Information

Participant's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_

University of Kentucky activities are covered by a plan administered by the Allen Flood Company. This insurance plan is secondary to the participant's own primary plan. For detailed information regarding the policy coverage benefits and limits please visit the U.K. Risk Management website at <http://www.uky.edu/EVPFA/Controller/riskhome/excess.html>.

**You MUST submit a copy of the front and back of all health insurance cards covering participant "With Registration."**

Check box and sign below if participant has NO health insurance coverage.

Signature (Parent/Guardian if claimant is a minor, under 18) \_\_\_\_\_ Date \_\_\_\_\_

### Consent to Medical Treatment/Insurance Statement

It is understood that authority is given to the UK activity director or their designee, to have my son/daughter treated for injuries or illness they incur during a UK camp, conference, or field trip activity.

In the event I cannot be contacted, I hereby give my permission for the UK activity director or their designee to seek advanced medical treatment for my son/daughter as deemed necessary by competent medical personnel.

I understand that the UK insurance coverage is on an "excess" basis only and I will be responsible for any expenses outside of the limits of UK's insurance.

### Authorization to Release Information

I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release any information regarding my medical treatment or benefits payable, including disability to any Allen Flood company, the Plan administrator or authorized personnel for the purpose of validating and determining benefits payable. This data may be extracted for use in audit or statistical purposes. I understand that I or my authorized representative will receive a copy of this authorization upon request. This authorization or a Photostat copy of the original shall be valid for the duration of the claim.

PAYMENT AUTHORIZATION: I authorize all current and future medical benefits for services rendered and billed as a result of this claim to be made payable to the physicians and providers indicated on the invoices.

Signature (Parent/Guardian if claimant is a minor, under 18) \_\_\_\_\_ Date \_\_\_\_\_

### Emergency Contact Information

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone number (during activity dates) \_\_\_\_\_ Additional number \_\_\_\_\_

### Medical Screen Form

Medical Screen Form (to be completed by a Physician) OR provide a copy of a physical exam form signed by a physician indicating clearance to participate. This form must be dated within 12 months of the date of the camp.

Head	Yes	No	
ENT	Yes	No	
Neck, Back	Yes	No	
Heart	Yes	No	
Abdomen	Yes	No	
Genitalia	Yes	No	
Extremities	Yes	No	

Asthma	Yes	No	(circle one)
Currently taking ANY prescription medication please list:	Yes	No	(circle one)
Date of Last Tetanus Shot or Booster			
Known Allergies			

Comments \_\_\_\_\_

Sports Participation Approved:  Yes  No Limitations:  Yes  No

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's Phone Number \_\_\_\_\_

**Disabilities accommodated with prior notification**