Neenah Joint School District

Jr. Visual Arts Academy

2014 Elementary

Participant Information Form

Child's Name

Date of Birth

Program Location

City and State

Grade Level Next Fall

Parent/Guardian Name

Street Address

City, State, and Zip Code

Parent/Guardian **Home** Phone Number

Parent/Guardian **Work** Phone Number

Program Rules

1. I will only leave the program with an adult that I know.
2. I will respect fellow students and instructors.
3. I will participate in all of the activities to the best of my ability.
4. I will act in a safe and responsible manner.
5. I will have fun!

I have read the Jr. Visual Arts Academy rules, and I will abide by these rules. I understand that the Jr. Visual Arts Academy staff has the right to remove any person from the program that does not abide by these rules. If I am asked to leave, I understand that my tuition is nonrefundable.

Child Signature Date

Parent/Guardian Signature Date

Alternate Contacts/Transportation Arrangements

In the event of an emergency, I authorize the following individual(s) to pick up my child from the program:

Name/Relationship
Number

Phone

Name/Relationship

Phone Number

My child may also: Walk and/or Ride his or her bicycle home

Parent/Guardian Signature Date

Photography Release

I authorize the Jr. Visual Arts Academy program to obtain, store, and/or use (without payment) any photographs, slides, and/or videotapes of my child for public relations, marketing/advertising, and/or internal training purposes.

Parent/Guardian Signature

Return registration form (one for each attending child) and payment of $45 in full to:

Brenda Mullard, Neenah High School 1275 Tullar Rd., Neenah WI 54956

Jr. Visual Arts Academy Emergency Medical Consent

In the event that reasonable attempts to contact me and the two alternate individuals that I have designated at the phone numbers that I have provided on this form have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by the physician, dentist, and/or hospital, as applicable, listed below:

Preferred Physician _____ Phone Number _____

Preferred Dentist _____ Phone Number _____

Preferred Hospital _____ Phone Number _____

In the event that the designated preferred physician, dentist, and/or hospital, as applicable, is not available, I hereby give my consent for the administration of any treatment deemed necessary by another licensed physician or dentist at any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists (as applicable), concurring in the necessity for such surgery, are obtained before surgery is performed.

Parent/Guardian Signature _____ Date _____

Emergency Medical Refusal

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to:

_____

_____

(Do not sign if Emergency Medical Consent was authorized above.)

Parent/Guardian Signature _____ Date _____

Participant Medical Information

Allergies (food, medication, etc.): _____

Activity restrictions or precautions: _____

List any medication child is currently taking: _____

My child is attending with an epinephrine syringe to be administered in the event of a severe allergic reaction.

IMPORTANT: *Epinephrine administration authorization forms must be completed by parents and the physician, and the Director must be trained in the administration of the epinephrine syringe* ***prior to the start date of the program****. Parents of participants with such severe allergies should Brenda Mullard personally.*

My child is carrying an inhaler and is authorized to self-administer as needed. *(Physician's order has been completed at the bottom of this form.)*

List any special needs, important medical history/behavior, and/or accommodations that can be made to make your child's experience more successful:

_____

_____

Physician's Order for Prescribed Oral Medication

All medication must be delivered in the original container in which it was dispensed and administered by a pre-authorized individual designated by the parent/guardian. ***No member of the Jr. Visual Arts program is permitted to administer medication.***

I have arranged, and hereby authorize, the administration of prescribed medication for my child to be handled as follows:

Name of Medication _____ Dosage _____

Name of Authorized Individual to Administer Medication _____ Date(s) and Time(s) of Administration (by aforementioned individual) _____

Name of Issuing Physician _____ Issuing Physician Emergency Phone Number _____

Significant side effects (adverse reactions) that should be reported to the physician: _____

Special instructions for use of drug, including storage: _____

Issuing Physician Signature _____ Date _____ Parent/Guardian Signature _____ Date _____

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