SUMMER 2018 PROGRAM REGISTRATION FORM

Weeks: ☐ June 4-8 ☐ June 11-15 ☐ June 18-29 ☐ June 25-29

Participant's Name: _____ Gender: M F Age: _____

Parent/Guardian's Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____

Email address: _____ How did you hear about us? _____

Alternative Emergency Contact (name, cell phone, relation):

_____

List any allergies or medical conditions. If no allergies, please write <u>none</u>: _____

_____

Primary Physician: _____ Phone: _____

Insurance Company: _____ Policy number: _____

By signing below, I agree with the following: If my child needs medical treatment while participating, it is my wish that the treatment be begun while efforts are being made to contact me. So that treatment is not delayed, I consent to any medical procedures that the physician believes needed, on the understanding that efforts will continue to be made to contact me. I accept responsibility for all cost related to such treatment.
By not signing below, treatment will not start until parent/guardian is contacted.

Signature of Parent/Guardian: _____

List anyone authorized to pick up your child (make sure they bring photo ID when picking up):

Name: _____ Phone: _____

Name: _____ Phone: _____

Photographic Release: I hereby give my consent to The Art of Science, LLC, or persons operating on its behalf, the unqualified right and permission to take photographs, slides, video or motion pictures of my child(ren) for the purpose of reproductions, publication and illustration in all forms of advertising and publicity media.

Parent/Guardian Signature: _____ Relationship: _____

or check the box: ☐ I do not give consent to use my child(ren)'s photos for advertising purposes.

Send this completed form with your check or money order to:

The Art of Science, LLC, P.O. Box 531922, Saint Petersburg, FL, 33747