

Art in Motion Camp – Participant Information Form

Participant Information

Name: _____ Likes to Be Called: _____

Address: _____

Date of Birth: _____ School/Grade: _____

Program Dates – Circle All that Apply: June 5-9 June 12-16 August 14-18

Contact Information

Parent/Guardian #1 Name: _____

Relationship to the Participant: _____

Contact Phone: _____ E-mail Address: _____

Parent/Guardian #2 Name: _____

Relationship to the Participant: _____

Contact Phone: _____ E-mail Address: _____

Childcare Provider Name: _____

Contact Phone: _____ E-mail Address: _____

Health Information

Physician & Phone Number: _____

Dentist & Phone Number: _____

Family Health Insurance Carrier & Policy Number: _____

Please list:

- Any known allergies:
- Any food restrictions:
- Any medications taken daily:
- Any activities in which the participant should not participate or may need extra help:
- Any behavioral tendencies or special needs:

Photo/Media Release

Please initial one:

_____ I DO grant permission for Local Motion Project and UpCycle Creative Reuse Center to use photos and videos of my child for educational and marketing purposes including printed materials, social media, and presentations. I understand that my child’s name will not be use in any of these materials.

_____ I DO NOT grant permission for Local Motion Project and UpCycle Creative Reuse Center to use photos and videos of my child for educational and marketing purposes including printed materials, social media, and presentations.

Pick-Up Authorization

List additional authorized individuals who may pick up the participant:

- Name: _____
Contact Phone: _____ Relationship: _____
- Name: _____
Contact Phone: _____ Relationship: _____

Parent/Guardian Authorization

This emergency information and health history are correct to the best of my knowledge, and the participant described herein has permission to engage in all activities, except as noted above.

I, as the parent/guardian, authorize Local Motion Project and UpCycle Creative Reuse Center personnel to seek emergency treatment as required and/or to transport my child to the appropriate medical facility in the event that urgent/emergency care is necessary. The hospital and its medical staff are authorized to provide any treatment, which is necessary for the well being of my child.

I understand that minor accidents or injuries will be treated on-site and that I will be notified of any such incidents and the treatment administered.

I understand that specific participant information may be shared with limited staff as may necessary and will be regarded as confidential.

I agree to hold Local Motion Project and UpCycle Creative Reuse Center and their officers, directors, members, staff and agents harmless for any injury to person or property not caused by negligence of the organization.

Signature _____
Date