

I STUDENT INFORMATION

Student's Name: _____ Student's Birthdate: ___/___/___

Address: _____ City: _____ State/ZIP: _____

Home Phone: _____ Student's Cell Phone: _____

Home Email: _____ Student's Email: _____

II PARENT/GUARDIAN INFORMATION

MOTHER

Mother or Guardian: _____ Occupation: _____

Employer: _____ Work Email: _____

Employer Address: _____

Work Phone: _____ Cell Phone: _____

FATHER

Father or Guardian: _____ Occupation: _____

Employer: _____ Work Email: _____

Employer Address: _____

Work Phone: _____ Cell Phone: _____

How did you hear about the Contemporary School of Fine Arts?

- web site school flyer referral Lamb School The MET
- friend school teacher other (please list) _____

III STUDENT MEDICAL INFORMATION

Emergency Contact (other than parent or guardian)

Phone

Physician's Name

Phone

Physician's Address

City

State/ZIP

Insurance Company

Phone

Subscriber Name

Policy Number

Group Number

Please list any known medical difficulties below:

Please list any current medications below:

List any known allergies:

Other Information:

IV MEDICAL AUTHORIZATION

I hereby grant to the Contemporary School of Fine Arts permission to take whatever action in its best judgment that may be necessary in supplying emergency medical services to my child, _____.

I understand that, consistent with the circumstances of the situation and available time, the Contemporary School of Fine Arts will make its best efforts to contact me, and follow the instructions of the parent or guardian, physician or other persons designated by me.

In the event that the Contemporary School of Fine Arts is unable to contact the parent or guardian, physician, or other person(s), I hereby grant permission to the Contemporary School of Fine Arts to contact and comply with the advice of an available physician, ambulance personnel or emergency room personnel. If I cannot be reached to make arrangements for the emergency medical care for my child at the time of an illness or accident, I give the Contemporary School of Fine Arts my permission to take my child (or children) to the physician detailed above.

By signing below, I give my consent for necessary emergency treatment when my child is in the care of this physician, hospital or clinic. I, the undersigned parent/guardian of the student named in this document who is a minor, do release, acquit, discharge, and covenant to hold harmless Metropolitan Baptist Church, (13000 Jones Rd, Houston, TX 77070) its sponsors and representatives from any and all actions, causes of actions, damages, and/or liabilities arising from the medical treatment of any sickness or injuries from accident incurred by my student during these activities.

Mother or Guardian/Date

Father or Guardian/Date

V GENERAL AUTHORIZATIONS

I, _____ hereby grant the Contemporary School of Fine Arts permission for my child/student to take part in the following activities.

Check all that apply:

- | | | |
|---|-----------------------------|------------------------------------|
| <input type="radio"/> Medical Release | <input type="radio"/> Grant | <input type="radio"/> Do Not Grant |
| <input type="radio"/> Field Trip | <input type="radio"/> Grant | <input type="radio"/> Do Not Grant |
| <input type="radio"/> Photographed or Videotaped | <input type="radio"/> Grant | <input type="radio"/> Do Not Grant |
| <input type="radio"/> Directory Release | <input type="radio"/> Grant | <input type="radio"/> Do Not Grant |

Signature of Parent/Guardian

Date

EMERGENCY CONTACT INFORMATION

CHILD'S NAME

ADDRESS

HOME NUMBER

WORK NUMBER: MOM

CELL NUMBER: MOM

WORK NUMBER: DAD

CELL NUMBER: DAD

EMAIL

AUTHORIZATION FOR CHILD PICK UP

NAME

RELATIONSHIP

PHONE NUMBER

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE INFORM THE OFFICE OF ANY CHANGES IN THIS INFORMATION.

Signature of Parent/Guardian

Print Name

Date