



mode music and performing arts

206-388-6688 | 3801 Delridge Way SW Seattle, 98106

|                            |                       |                |
|----------------------------|-----------------------|----------------|
| <b>Student First Name:</b> | <b>Birth Date:</b>    | <b>Gender:</b> |
| <b>Student Last Name:</b>  | <b>Student Email:</b> |                |

|                           |  |                         |                               |                               |
|---------------------------|--|-------------------------|-------------------------------|-------------------------------|
| <b>Parent/Guardian #1</b> | <input type="checkbox"/> Mother<br><input type="checkbox"/> Father<br><input type="checkbox"/> Stepmother<br><input type="checkbox"/> Stepfather<br><input type="checkbox"/> Other | Primary Phone: (    )   | <input type="checkbox"/> Home | <input type="checkbox"/> Cell |
| Last Name:                |  | Secondary Phone: (    ) | <input type="checkbox"/> Home | <input type="checkbox"/> Cell |
| First Name:               |  | Employer:               |                               |                               |
| Parent Email:             |  | Work Phone: (    )      |                               |                               |
| Home Address:             |  | City:                   | State:                        | Zip:                          |

|                           |  |                         |                               |                               |
|---------------------------|--|-------------------------|-------------------------------|-------------------------------|
| <b>Parent/Guardian #2</b> | <input type="checkbox"/> Mother<br><input type="checkbox"/> Father<br><input type="checkbox"/> Stepmother<br><input type="checkbox"/> Stepfather<br><input type="checkbox"/> Other | Primary Phone: (    )   | <input type="checkbox"/> Home | <input type="checkbox"/> Cell |
| Last Name:                |  | Secondary Phone: (    ) | <input type="checkbox"/> Home | <input type="checkbox"/> Cell |
| First Name:               |  | Employer:               |                               |                               |
| Parent Email:             |  | Work Phone: (    )      |                               |                               |
| Home Address:             |  | City:                   | State:                        | Zip:                          |

|                           |  |                         |                               |                               |
|---------------------------|--|-------------------------|-------------------------------|-------------------------------|
| <b>Parent/Guardian #3</b> | <input type="checkbox"/> Mother<br><input type="checkbox"/> Father<br><input type="checkbox"/> Stepmother<br><input type="checkbox"/> Stepfather<br><input type="checkbox"/> Other | Primary Phone: (    )   | <input type="checkbox"/> Home | <input type="checkbox"/> Cell |
| Last Name:                |  | Secondary Phone: (    ) | <input type="checkbox"/> Home | <input type="checkbox"/> Cell |
| First Name:               |  | Employer:               |                               |                               |
| Parent Email:             |  | Work Phone: (    )      |                               |                               |
| Home Address:             |  | City:                   | State:                        | Zip:                          |

Does your child have any medical, emotional or behavioral issues that may affect their participation in our program?  No  Yes *(please complete Medical Information form)*

Does your child take any medication?  No  Yes *(please complete Medical Information form)*

Does your child have allergies?  No  Yes *(please complete Medical Information form)*

I, the undersigned parent/guardian of the registrant, acknowledge the possibility that participation in MMPA activities could result in physical injury to the registrant. I hereby release, discharge and agree to hold harmless MMPA, its officers, directors, employees, agents and affiliates from any and all claims arising from or related to the registrant's participation in MMPA activities. I further authorize MMPA staff to obtain medical care for my child in case of an emergency. I certify that I have read, understood, and agree to the above conditions, and that the information provided is complete and accurate to the best of my knowledge.

Physician: \_\_\_\_\_ Phone: (    )

Insurance Carrier: \_\_\_\_\_ ID#

When injury, illness or other emergency situations involving your child occur, we want to be able to quickly reach you or other responsible adults. In the event we cannot reach a parent/guardian, please list person(s) you trust who are available during the day to provide care for your child, including day care contact.

**Student Release Authorization:** *In the event MMPA is unable to contact the parent/guardian, I authorize them to release my child to the person(s) listed below.*

|          |               |               |
|----------|---------------|---------------|
| 1) Name: | Relationship: | Phone: (    ) |
| 2) Name: | Relationship: | Phone: (    ) |
| 3) Name: | Relationship: | Phone: (    ) |
| 4) Name: | Relationship: | Phone: (    ) |

Check if you **do not** give your permission to use photos or videos of your child for publicity purposes.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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Rev 12/2017

**COMPLETE THIS FORM ONLY IF YOU ANSWERED YES TO MEDICAL QUESTIONS**

Parents/guardians are responsible for informing MMPA if a student has a serious health condition. This information will be shared with staff only as needed.

|   |                             |   |
|---|-----------------------------|---|
| <b>Student:</b> (last) _____ (first) _____  | <b>Birth Date:</b> _____    | <b>Gender:</b> _____  |
| <b>Parent:</b> (last) _____ (first) _____   | Primary Phone: (    ) _____ | <input type="checkbox"/> Home <input type="checkbox"/> Cell |
| Please explain your child's serious health condition: (for example diabetes, severe allergies, epilepsy/seizure disorder, severe asthma, or cardiac/heart conditions)   |                             |   |
| We want to create a successful experience for your child. Please explain any medical, behavioral, or emotional challenges that may impact your child's experience and the best ways we can help your child be successful. |                             |   |

**Please list any medications your child currently takes:**

| Medication | Dose/Frequency | Taken at Home            | Taken during class/camp  | Will Self-Administer     | Notes |
|------------|----------------|--------------------------|--------------------------|--------------------------|-------|
|            |                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |       |
|            |                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |       |
|            |                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |       |
|            |                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |       |

Any medication brought to class/camp should be kept in the student's backpack.\* Let us know if alternative arrangements should be made for any reason. Refrigeration will not be available. **If your student cannot self-administer medication, you must make arrangements for a person known to the child to come to camp or class and administer medication.** Please advise the camp or class teacher of the person's name and arrival time in advance. If your child needs prompts to take medication, or needs to report on medications taken during class/camp, please make arrangements to have your child carry a cell phone. **Instructors cannot be responsible for administering or monitoring student medication.**

**Please list any allergies about which our staff or medical personnel should be aware:**

| Allergen | Reaction | Treatment |
|----------|----------|-----------|
|          |          |           |
|          |          |           |
|          |          |           |
|          |          |           |

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\*EpiPens will be kept with the First Aid kit at camp. In cases of severe allergic reaction, instructors are trained to administer EpiPen to outer thigh, call 911 and then call parents. Please remember to pick up your EpiPen from staff on the last day.

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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