

# CORCORAN

GALLERY OF ART • COLLEGE of ART + DESIGN

## Studio D 2010 Information and Release Form

Please fax completed form to (202) 639-1729 or mail to:

Studio D  
Corcoran Downtown Campus  
500 Seventeenth Street NW  
Washington, DC 20006

Questions? Call (202) 639-1805.

### Section A: Student Information

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age (as of July 1, 2010): \_\_\_\_\_ Grade (Fall 2010): \_\_\_\_\_

School (name, city): \_\_\_\_\_

### Section B: Parent/Guardian Contact Information

Mother/Guardian: \_\_\_\_\_ Day Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Email: \_\_\_\_\_ Cell Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Father/Guardian: \_\_\_\_\_ Day Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Email: \_\_\_\_\_ Cell Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

### Section C: Emergency Contact Information

(when neither parent/guardian can be reached)

1. Name: \_\_\_\_\_ Relation to child: \_\_\_\_\_

Day Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Cell Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

2. Name: \_\_\_\_\_ Relation to child: \_\_\_\_\_

Day Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Cell Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

**Section D: Confidential Medical Information**

Physician's Name: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Food/Medical Allergies (Please list ALL): \_\_\_\_\_

Does your child take any medications regularly? NO \_\_\_\_ YES \_\_\_\_ If YES, please describe below.

1. Type: \_\_\_\_\_ Reason for medication: \_\_\_\_\_ Dosage/Fequency: \_\_\_\_\_

2. Type: \_\_\_\_\_ Reason for medication: \_\_\_\_\_ Dosage/Fequency: \_\_\_\_\_

3. Type: \_\_\_\_\_ Reason for medication: \_\_\_\_\_ Dosage/Fequency: \_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_ Health Insurance Carrier: \_\_\_\_\_

Group Number: \_\_\_\_\_ Identification Number: \_\_\_\_\_

Does your child have any chronic medical conditions, illness, or physical limitations that might inhibit his or her ability to participate in camp activities? NO \_\_\_\_ YES \_\_\_\_ If YES, please describe:

\_\_\_\_\_  
\_\_\_\_\_

**Section E: Medical Release**

I hereby authorize any health plan-participating or non-participating physician, hospital, or other health care provider to give emergency medical care and treatment to the above-named child at no cost to the Corcoran Gallery of Art and College of Art + Design. The undersigned has read this medical authorization consent form and declares and affirms consent to the content herein stated. I assume all financial responsibility and waive all claims or future claims against the Corcoran for any injuries sustained by the above-named child.

**AND**

I understand that if my child becomes ill or is injured and I cannot be reached, the staff of the Corcoran will direct my child be taken to a physician, hospital, etc., as recommended by an attending physician.

The information on this form will be shared solely with Studio D staff and the instructor. By signing this form, I confirm that I have read, understood, and agree with its content.

Parent/Guardian SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Name PRINTED: \_\_\_\_\_

**Section F: Photographic Release**

I authorize the photographing, videotaping, and/or interviewing of my child during Studio D and understand that the resulting photographs, videotapes, or interviews may be published and used to promote Corcoran Gallery of Art and College of Art + Design programs. I also give the Corcoran permission to reproduce photographs taken of my child's artwork for promotional purposes.

Parent/Guardian SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Name PRINTED: \_\_\_\_\_