

# CORCORAN

GALLERY OF ART • COLLEGE of ART + DESIGN

## Aspiring Artists Information and Release Form

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

Youth and Family Programs  
Corcoran Downtown Campus  
500 Seventeenth Street NW  
Washington, DC 20006

Questions? Call (202) 639-1805.

### Section A: Student Information

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

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Grade (2009–2010 School Year): \_\_\_\_\_

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

### Section B: Parent/Guardian Contact Information

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

E-mail: \_\_\_\_\_ Cell Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

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

E-mail: \_\_\_\_\_ 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 certain 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 Corcoran 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 arrange for my child be taken to the nearest physician, hospital, etc., recommended by an attending physician.

The information on this form will be shared solely with Youth and Family staff and the class teacher.

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 class and understand that the resulting photographs, videotapes, or interviews may be published and used to promote Corcoran Gallery of Art and Corcoran 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: \_\_\_\_\_