

# CHILDREN'S MUSEUM EMERGENCY INFORMATION FORM AND AUTHORIZATION

Student's Name: _____		
In case of emergency please contact:		
Name _____	Phone _____	Cell _____
Name _____	Phone _____	Cell _____
Name _____	Phone _____	Cell _____

Family Doctor: _____	Phone: _____
Family Dentist: _____	Phone: _____
Allergies (including insect stings): _____	
Please answer the following medical questions that would be of concern while your child is attending this program:	
Chronic or recurring illnesses: _____	
Medications currently taking: _____	

**PARENT AUTHORIZATION AND WAIVER** In consideration of this entry to the program offered by the Children's Museum, I waive all claims which I have or may have against the Children's Museum, Inc., or its agents, for any injury or illness which may result from my child's participation. I further state that my child is in proper physical condition to participate in this program, as certified by a licensed physician, and has my permission to engage in all prescribed activities, except as noted by me or my child's physician. This information/health history is correct as far as I know. In the event that I or a designated emergency contact person cannot be reached for an emergency, I hereby give permission to the physician selected by the instructor to secure proper and necessary medical treatment for my child.

**PHOTO RELEASE** I give my permission to The Children's Museum, Inc., to use my child's name and/or picture in any paper, broadcast, or telecast without any obligation of anyone to compensation.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## For programs with children 6-14 years of age:

Who will pick the student up? \_\_\_\_\_

Or  
Will the student walk home?      YES      NO