Summer Arts Workshop Request

Please complete both sides of this form

Name:_____

Parents Name: _____

Current School: _____ Current Grade: _____

Address: _____

_____

Home Phone:_____ Email: _____

Emergency contact other than parent: _____

Relationship to child:_____ Phone: _____

Classes Requested:

_____ _____ _____

Choice 1 Choice 2 Choice 3

If you selected band or orchestra, please list the instrument you will be learning:

_____

Do you currently play this instrument: Yes No

If yes, how long have you played: _____

To provide opportunities for as many students as possible, student may only be able to participate in once course. Once all students requesting classes have been enrolled, we will allow students to participate in additional classes on a space-available basis.

Class requests and completed and signed medical release and permission form should be returned by **May 13 to Lori Rotherham at Vancouver School of Arts and Academics**, 3101 Main Street, Vancouver, WA 98663. **Late registrations will not be accepted**.

Parents will be notified regarding their student's enrollment by the last day of school. Please email lori.rotherham@vansd.org with questions.




VANCOUVER PUBLIC SCHOOLS
CONSENT TO PARTICIPATE IN AFTER SCHOOL PROGRAM AND MEDICAL TREATMENT CONSENT FORM

THE UNDERSIGNED HEREBY GIVES PERMISSION AND AUTHORIZES _____
Student's Name

TO ATTEND THE FOLLOWING AFTER SCHOOL/EXTENDED DAY PROGRAMS _____

_____ DATES OF ATTENDANCE_____

Consent for Medical Treatment

This is to authorize emergency medical care and treatment for my son/daughter in my absence. Every reasonable effort will be made to contact me if such action is necessary.

FAMILY PHYSICIAN	HOSPITAL PREFERENCE
NAME OF INSURANCE CARRIER	GROUP/CHART NUMBER

If your student will need to bring prescribed medication, the Authorization for Medication Administration form (enclosed) must be completed and signed by the health care provider and parent/guardian. For over-the-counter medications, please check with your school nurse for procedure.

DOES YOUR CHILD TAKE ANY MEDICATION? _____ If yes please list:_____

DOES YOUR CHILD HAVE ANY HEALTH CONCERNS THAT THE TEACHER NEEDS TO BE AWARE OF? _____

_____

I UNDERSTAND THAT THE STUDENT WILL BE SUPERVISED BY SCHOOL AUTHORITIES AND THAT EVERY EFFORT WILL BE MADE TO ENSURE STUDENT SAFETY.

I WILL ASSUME FINANCIAL RESPONSIBILITY FOR EMERGENCY MEDICAL TREATMENT FOR MY CHILD.

PARENT/GUARDIAN SIGNATURE	DATE
EMERGENCY CONTACT NAME	PHONE/RELATIONSHIP

NOTE: THIS CONSENT FORM MUST BE SIGNED AND RETURNED TO SCHOOL PRIOR TO THE DESIGNATED DATE OF PROGRAMS ATTENDED.