Solicitud de Ingreso Talleres Artísticos de Verano

Por favor complete ambos lados de esta forma.

Las solicitudes de ingreso también pueden someterse por medio de "*Google Form*", siguiendo el enlace de "*Summer Arts*" en la página web del Distrito Escolar ("*VPS*").

Nombre del Estudiante: _____

Nombre(s) del Padre de Familia/Tutor: _____

Escuela Actual: _____ Grado: _____

Dirección de la Casa: _____

_____

Número telefónico del Padre de Familia/Tutor:

Correo Electrónico del Padre de Familia/Tutor: _____

Contacto de Emergencia (aparte del Padre de Familia): _____

Relación con el Estudiante: _____

Número telefónico del Contacto de Emergencia: _____

Preferencias de talleres:

Para ofrecer la oportunidad de participación al mayor número de estudiantes posible, cada estudiante sólo será inscrito en uno de los Talleres Artísticos de Verano. Por favor indique la primera, segunda y tercera preferencia, escribiendo los números 1, 2 y 3 en las casillas junto a los talleres de preferencia.

☐ **Exploradores del Arte y Literatura**
(Primaria King, julio 23-27, grados 1-4)

☐ **Principios de la Improvisación**
(VSAA, julio 23-27, grados 4-7)

☐ **Taller de Danza**
(VSAA, julio o9-13, grades 3-6)

☐ **Exploración Musical y Composición de Canciones** *(Primaria Minnehaha, julio 9-13, grados 2-6)*

☐ **Exploración Musical y Composición de Canciones** *(Primaria Lake Shore, julio 16-20, grados 2-6)*

☐ **Producción Musical y Grabación de Estudio Musical**
(VSAA, julio 9-13, grados 8-11)

☐ **Línea de Percusión**
(Primaria Marshall, julio 9-13, grados 2-5)

☐ **Taller Intensivo de Teatro Físico**
(VSAA, julio 9-19, grados 7-11)

☐ **"Shakespeare" en el Patio**
(VSAA, julio 9-agosto 18, grados 8-11)

☐ **Coro Español**
(Primaria Roosevelt, julio 9-13, grados 2-5)

☐ **Coro de Verano**
(Primaria Roosevelt, julio 9-13, grados 2-5)

☐ **Taller de Coreografía para Adolescentes**
(VSAA, julio 16-20, grados 8-11)

☐ **¿Cuál es tu Historia?**
(VSAA, agosto 6-10, grados 3-4)

Esta solicitud y la Forma de Autorización de Divulgación de Información Médica, completada y firmada (en el reverso) deberán entregarse a más tardar el viernes, 18 de mayo. Las formas se pueden entregar por correo, correo electrónico o en persona a **Brienne Schneider** en la **Escuela Vancouver School of Arts and Academics** (3101 Main Street, Vancouver, WA 98663) o Vps.Arts@vansd.org. Los padres de familia serán notificados por correo electrónico a qué taller artístico habrá sido asignado su estudiante antes del último día de clases del año escolar 2017-18.

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.

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN VANCOUVER SCHOOL DISTRICT

(Excludes ointments, eye, nose or ear drops, suppositories and medication inhaled through the nose)

Student's Name: _____ School Year: _____

DOB: _____ Gr.: _____ School: _____ School Fax: _____

THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH PROFESSIONAL (LHP) PRESCRIBING WITHIN THE SCOPE OF THEIR PRESCRIPTIVE AUTHORITY

Name of Medication: _____

Dosage/Frequency: _____

Diagnosis or reason for medication: _____

If given PRN, specify the length of time between doses: _____

Possible major side effects of medication: _____

What observable side effects do you want us to report: _____

Student is capable of carrying/administering inhaler Yes ☐ No ☐ and/or Epi-pen Yes ☐ No ☐

I request and authorize that the above-named student be administered the above identified oral medication or Epi-Pen injection in accordance with the instructions indicated above from _____ to_____ (not to exceed current school year), as there exists a valid health reason which makes administration of the medication advisable during school hours.

Licensed Health Professional	Clinic Name	Date
Name (Print or type)	Telephone	Fax

Please note:

1. Prescribed medication must be provided in the container labeled by the pharmacist with the name of your child, the name of the medication, the dosage and frequency in which the medication is to be given.
2. Over the counter medications must be in the original container.
3. If samples of medication are to be given, they must be labeled with the name of the student, dosage, and time to be given.
4. Medications must be brought to the school by the parent/ guardian.

THIS PORTION TO BE COMPLETED BY THE PARENT/ GUARDIAN

I request and authorize the school to administer medication to the above identified student in accordance with the health care provider's instructions. Confidentiality of information provided to my student's school district is protected by the federal Family Educational Rights and Privacy Act. I may revoke this authorization by writing to my student's school district. If I did, it would not affect any actions already taken by the school district based upon this authorization.

Once health care information is disclosed, the person or organization who receives it may re-disclose it only in conformance with applicable confidentiality laws.

You have my permission to communicate with this health care provider in order to make arrangements for the care and supervision of my child. I give the health care professional:

Permission to fax this form to the school	☐ Yes	☐ No
Permission for my student to carry and self-administer inhaler	☐ Yes	☐ No
Permission for my student to carry and self-administer Epi-pen	☐ Yes	☐ No

I understand the district shall incur no liability as a result of any injury arising from the self-administration of medication by the student, and parents/guardians shall indemnify and hold harmless the district and its employees or agents against any claim arising out of the self-administration of medication by the student.

Parent/Guardian Signature	Date of Signature