Camp Teacher______________________________

HILL COUNTRY ARTS FOUNDATION - YOUNG ARTIST'S CAMP
Medical and Photo Release Form

CAMPER'S NAME ____ Age: _________

CAMP DATES ATTENDING: ____

PARENT'S NAME ____

ADDRESS ____

CITY, STATE ZIP ____

EMAIL ____

PARENT'S PHONE NUMBER DURING CAMP HOURS: ____________________________

AN ALTERNATE NUMBER (FRIEND OR RELATIVE): ____________________________

LIST ANY MEDICAL CONDITION OR ALLERGY THAT HCAF SHOULD BE AWARE OF DURING CAMP:

YOUR CHILD'S PHYSICIAN:____

PHYSICIAN'S PHONE NUMBER:____

PLEASE READ AND INITIAL TO GIVE PERMISSION FOR THE FOLLOWING TERMS:

______ In the event that I cannot be reached in case of a medical emergency, I give my permission for the staff of HCAF to seek medical attention for my child.

______ I understand that if my child demonstrates inappropriate behavior he/she will be dismissed from participation in Art Camp for the remainder of the week.

______ I give permission for photographs taken of my child at art camp to be used in HCAF promotional displays and materials.

I GIVE PERMISSION FOR THE FOLLOWING PEOPLE TO PICK MY CHILD UP FROM ART CAMP.

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PARENT
SIGNATURE:____DATE______________

PLEASE PRINT NAME CLEARLY ____

Optional Ethnicity Information: *Granting agencies request ethnicity information of those served by HCAF. Please help us give an accurate report.*

☐ American Indian/Alaskan Native

☐ Asian ☐ Hispanic ☐ Native Hawaiian/Pacific Islander

☐ Black ☐ White ☐ Multi-Racial