STUDENT INFORMATION FORM 2016

PCCC – Founder's Theater
February - June 2016
Arts Workshops
(Saturdays 10 am -12:30 pm)

_____ M / F
Child's Name: First Last Gender

_____ _____
Address: Street City State Zip Date of Birth

_____ _____
School Attending Grade

Parent/Guardian _____ Cell# _____

Primary E-mail _____

Release: I authorize the following person(s) to pick up my child from the ICE classes.

Name _____Relationship: _____Phone_____

Name _____Relationship: _____Phone_____

Medical History: My child has the following medical conditions (allergies, asthma, injuries, etc.)

_____, _____

Permission for Medical Treatment (Optional)
In case of a medical emergency, I, _____ authorize the personnel of Public School # 2 to take my child to St Joseph's Medical Center for treatment.

(OR) **Emergency Contact_____ Cell #_____**

Secondary Contact Person_____ Cell # _____

Health / Insurance Information:
Company: _____ Policy Number: _____

Name of Insured: _____

Parent's Signature _____ Date: _____

Press Release Statement:

I, (print name) _____, grant **ICE, the New Jersey State Council on the Arts, PCCC** and **The Passaic County Cultural and Heritage Council, and City of Paterson/Department of Health & Human Services**permission to use my / my child's photograph:

Signature: _____ _____
(Parent or Guardian must sign if child is under 18) Date