Emergency Information & Authorization Form

The information provided on this form will be used to ensure safe participation of your child in Wayne Center for the Arts programming. A completed form must be submitted before start of participation.

Name	Preferred Method of Communication: ☐ Text ☐ Phone Call ☐ Email		
Address	City	State	Zip
Primary Phone (identify if work, home or cell)	Secondary Phone (identify if work, home or cell)		
Age	Birthdate		
Parent/Guardian Name	Other Parent/Guardian Name		
Primary Email Address	Secondary Email (if necessary)		

In the event the parent/guardian(s) listed above cannot be reached, please contact:

Name	Primary Phone

The above emergency contact has permission to sign student in/out of class ☐ Yes ☐ No

ACTIVITIES CONSENT: I, the undersigned, being the parent or legal guardian of the student named above, do hereby consent to the participation of my child in all dance program-related activities of Wayne Center for the Arts, including but not limited to rehearsals and live performances, and any other supervised activities customarily associated with the dance program. Further, I certify that my child is physically fit and adequately prepared to participate in all recreational and dance activities, and I assume any and all liability for any injury associated with any dance program activities, including but not limited to transportation to or from the same. If I wish to revoke this consent for any reason, I will promptly notify the center in writing.

I give permission for the administration of any treatment deemed necessary by my preferred physician or dentist.

Physician's Name	Physician's Primary Phone
Dentist's Name	Dentist's Primary Phone

In the event the preferred practitioner is not available, I consent to treatment by any appropriate health care professional who is available.

I give permission for the transportation of my child to the preferred hospital or another hospital reasonable accessible. I hereby assume full responsibility for payment of such treatment and have attached copies of my child's medical insurance card, and if applicable, dental insurance cards.

Hospital Name

I authorize my child age 11 or older to sign themselves in/out of class. ☐ Yes ☐ No

Medications*

**WCA staff members are not permitted to dispense medication other than Emergency Medication to students. A designated adult must dispense non-emergency medication to students during class time. Emergency Medication must be labeled with the child's full name and provided to WCA at registration. By signing this form, you give WCA staff and instructors permission to administer Emergency Medication if necessary.*

Please give a complete description of all allergies and describe other medical, behavioral, or developmental issues of which we should be aware:

Students with a behavioral or developmental diagnosis must complete the special needs form.

I authorize WCA to take and use photographs and/or record and use videos of my child and his/her work for promotional purposes without any compensation. Such uses may include, but are not limited to, WCA online and print publications or submissions to the press for use in articles or advertisements.

Parent/Guardian Signature:	**Date:**

2021 Summer Special Needs Form

In order to ensure that your child has the highest quality experience possible while enrolled in Wayne Center for the Arts programming, we ask that you provide us with either an IEP or complete the short questionnaire below regarding your child's diagnosis. This information will only be shared with adults directly responsible for the supervision, safety and/or instruction of your child.

Describe possible triggers your student might have and any methods that are used at home or in school to avoid negative responses.

Describe individualized goals you have for your student within the parameters of the program.

Describe reward systems and/or soothing methods that you have found to be effective at home or in school.

Please indicate any additional information that you feel might be helpful.

If a Therapeutic Support Staff (TSS) or Aide will accompany the enrolled student, they must register during the first day of class.

Name(s) of TSS or Aide _____

Email _____

Name of Agency _____ Phone Number _____

Street Address _____

City _____ State _____ Zip Code _____

Name of TSS Supervisor or Behavior Specialist Consultant _____

Parent/Guardian Signature _____ Date _____