Peggy R. McConnell Arts Center of Worthington

ADVISED CONSENT RELEASE

Class Name_____

Date: _____

Child/ Children's Name (s): _____

Parent/Guardian Name: _____

Address/City/State/Zip: _____

In consideration of _____**(Name of Child(ren)/Ward(s))** being permitted to participate in the class conducted, sponsored or organized by the McConnell Arts Center, the undersigned, for himself/herself, his/her spouse, legal representatives, heirs and assigns, hereby releases the McConnell Arts Center their officers, trustees, agents, and employees (the "Releasees") from any and all liability to the undersigned, his/her spouse, legal representatives, heirs and assigns, for any and all losses or damages, any claim for damages resulting therefrom, on account of injury to person or property, even injury resulting in death, while the child(ren)/ward(s) is in any way participating in the class.

The undersigned agrees to indemnify the Releasees from any loss, liability, damage or cost they may incur due to the activities of the child/ward in or upon McConnell Arts Center.

The undersigned expressly agrees that this Advised Consent Release is intended to be as broad and inclusive as permitted by the laws of the State of Ohio, and that if any portion thereof is held invalid, the balance shall continue in full legal force and effect.

_____

Signature of Parent or Legal Guardian **Date**

****

Peggy R. McConnell Arts Center of Worthington

AUTHORIZED PICK-UP/ DROP-OFF PROCEDURE ACKNOWLEDGMENT

Child's Name: _____

Child's Age/Grade Level: _____/_____

Parent/Guardian: _____

Names/Relationship of Additional Adults Authorized to Pick-Up/Drop-Off:

_____

I (the Parent/Guardian or Additional Authorized) acknowledge that the Peggy R. McConnell Arts Center of Worthington has required that a parent/guardian walk their student to and from classes to help ensure the child's safety both when arriving and departing classrooms at the McConnell Arts Center.
(PLEASE CHECK BOX(ES) BELOW)

☐ **I will walk my child to their designated classroom upon both arrival and departure of each class session.**

OR

☐ **I wish to allow my child, who is age 8 or older, to arrive and depart the enrolled class without being accompanied by a parent/guardian.**

- ☐ My child may sign themselves in/out each day.

And

- ☐ My child may ride a bike to and from the Peggy R. McConnell Arts Center of Worthington.
- ☐ My child may ride a bus to and from the Peggy R. McConnell Arts Center of Worthington.
- ☐ My child may walk to and from the Peggy R. McConnell Arts Center of Worthington.

I fully assume all responsibility for my child's safety and have chosen to waive any child pick-up and drop-off procedures. I agree to indemnify and hold harmless the Peggy R. McConnell Worthington Center for the Arts and any and all of their agents, consultants, assigns, contractors/subcontractors, employees, and all others contracted by or working in service to any of the foregoing parties, from any loss, injury, claim, damage, accident, or cost, which may result from my child's arrival and departure, including attorney's fees of defense.

By signing below, I acknowledge that I have read and understood this Authorized Pick-up/Drop-off Procedure Acknowledgment and agree to abide by its terms.

_____ _____
Parent/Guardian Signature Date

Peggy R. McConnell Arts Center of Worthington

EMERGENCY & GENERAL INFORMATION FORM

Participant's Name: _____ Date of Birth: _____

Name of Doctor: _____ Doctor's Phone #: _____

Does the participant have any disabilities or physical conditions of which the MAC personnel should be aware?
Yes ____ No ____

If yes, please explain:

_____

_____

Known allergies: _____

Other conditions: _____

Date of last tetanus booster: _____

IN CASE OF EMERGENCY:
Please list two phone numbers for all parents/legal guardians, plus one other responsible friend/family member.
NOTE: CHILDREN WILL NOT BE ADMITTED WITHOUT THIS INFORMATION.

Name	Relation	Address	Cell/Home #	Work/Other #

EMERGENCY MEDICAL AUTHORIZATION

Part I: In the event reasonable attempts to contact the authorized persons have been unsuccessful, I hereby give my permission for the administration of any treatment deemed necessary by Dr._____(preferred physician), or in the event the designated preferred practitioner is not available, by another licensed physician, and the transfer of the child to_____ Hospital or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Medical Insurance Carried: _____

Parent/Guardian Signature: _____ Date: _____

PART II – REFUSAL TO CONSENT: I do not give consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish MAC personnel to take no action, or to

_____

Parent/Guardian Signature: _____ Date: _____