**Brave Arts Theatre Workshop**

**Medical Authorization and Release**

While my son/daughter is attending Brave Arts Theatre Workshop at Cambridge School of Weston in Weston, MA, I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (print name), the parent/guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (print name) authorize Brave Arts Theatre Workshop to obtain emergency medical treatment for my son/daughter if, in the opinion of the counselors, Health Supervisor or Health Care Consultant my son/daughter is in need of emergency medical treatment. Brave Arts agrees to contact the parents or guardians of each participant as soon as is reasonably practical. The telephone numbers I provide on the emergency contact form are where Brave Arts will contact me.

Unless otherwise indicated on the *allergies, intolerances and special needs form* I give consent for the staff of Brave Arts to apply sunscreen to my child if the program is outside for extended periods of time. I also consent that in the case of basic First Aid needing to be administered, Health Care supervisor Sarah Clancy will perform any necessary procedure.

 I further agree that I will be responsible for the payment of any case of medical treatment of any nature which may arise in connection with any sickness or accident which may occur during the period that my son/daughter is at Brave Arts program, whether such expense is incurred during or subsequent to the time that my son/daughter attends Brave Arts program and will identify and hold harmless Brave Arts for any claims for payment by providers of said medical care.

Participant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participant Age as of 07/08/19: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Brave Arts Theatre Workshop**

**Authorization to Administer Medication**

(To be completed by parent/guardian)

Name of Participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone Number:

Emergency Contact Name: \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food/Drug Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis (at parents discretion): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Licensed Prescriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_

Business Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Medication: Dose given at Brave Arts: \_\_\_\_\_\_\_\_\_ Route of Administration:

Frequency: \_\_\_\_\_\_\_ Quantity Received:\_\_\_\_\_\_\_\_\_\_\_

Special Storage Requirements:

Specific Directions (e.g., on empty stomach/with water):

Specific Precautions:

Possible Side Effects/Adverse Reactions:

Other medications (at parents’ discretion):

Location where medication administration will occur:

I hereby authorize **Sarah Clancy** to administer, to my child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When no longer needed, medications shall be returned to a parent of guardian whenever possible. If the medication cannot be returned, it shall be destroyed.

\*Health Supervisor – A person who is at least 18 years of age, specially trained and certified in at least current American Red Cross First Aid (or its equivalent) and CPR, has been trained in the administration of medications and is under the professional oversight of a licensed health care professional authorized to administer prescription medications.

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Brave Arts Theatre Workshop**

**Pick-up Authorization**

I understand that pick-up time for ***DAY sessions of Brave Arts*** is at 3:00 p.m. promptly Monday-Friday. Any parents or guardians who attend the Friday performance at the end of each session are welcome to take their child at the end of the performance. Any parent, guardian or authorized pick-up adult MUST contact Sarah Clancy at (508) 314-1792 if you believe you will be late for pick up.

I understand that pick-up time for ***BOARDING sessions of Brave Arts*** is on Friday at 3:00 p.m. All participants must be moved out of the dorms by 5:00 p.m. on Friday July 19 for the first session and 5:00 p.m. on Friday July 26 for the second session. Staff will be present to assist parents and participants during the move-in and move-out periods.

Please provide below the name, telephone number, email address and relationship of authorized pick-up adults. If any of the approved pick-up adults are parents or guardians of other Brave Arts’ participants PLEASE WRITE THE CHILD’S NAME in “relationship.”

1. Name:
	1. Telephone Number:
	2. Email Address:
	3. Relationship:
2. Name:
	1. Telephone Number:
	2. Email Address:
	3. Relationship:
3. Name:
	1. Telephone Number:
	2. Email Address:
	3. Relationship:

**Brave Arts Theatre Workshop**

Allergies, Intolerances & Special Needs

Please use this space to describe any food, medicine or other allergies or intolerances and any special dietary or behavioral needs that you feel we should be aware of. Since we will be in the cafeteria for meals we pay special attention to intolerances and allergies and work closely with our meal providers to make sure your child’s meals are free of allergens. We may contact you regarding the allergy or intolerance and you can always feel free to contact Sarah at (508) 314-1792.