

HEALTH FORM

Student Full Name (LAST, First, Middle)		
/	/	
Birthdate	Age	Sex
Healthcare Plan		
ID#		
Parent/Guardian Full Name		Relationship to student
()	()	
Daytime Phone	Alternate Phone	
Alternate Contact		Relationship to student
()	()	
Daytime Phone	Alternate Phone	

PART I: HEALTH INFORMATION

Basic Health History:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dietary restrictions | <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Trouble with ears |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Fainting | <input type="checkbox"/> Hives | <input type="checkbox"/> Trouble with eyes |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Food allergies | <input type="checkbox"/> Hyperactivity | |
| <input type="checkbox"/> Communicable diseases | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Severe allergic reactions | |
| <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Shortness of breath | |

Allergies:

- | | |
|---|---|
| <input type="checkbox"/> Bee stings | <input type="checkbox"/> Food allergies |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> other (specify): _____ | |

Please comment on all checked items (use extra sheet if needed):

Immunizations: Is your child up to date on all state-required immunizations? Yes No

(If no, please explain.)

Medications: Is your child taking any medication we should know about? Yes No

Bravo School of Art Staff is not able to dispense medication.

Is there anything else - health related or not - that you would like us to know about this student?

PART II – CONSENT TO TREATMENT OF MINOR

The undersigned, as a parent or legal guardian of _____

Student's full name – please print clearly

hereby authorizes Bravo School of Art and its staff members to consent to any medical and hospital care to be rendered to said minor upon the advice of a licensed physician. It is understood that if time and circumstances reasonably permit, Bravo School of Art will endeavor, but is not required to communicate with the undersigned prior to such treatment. The undersigned further agrees that Bravo School of Art and its staff members are not legally or financially liable for any claim arising from any consent given in good faith in connection with such diagnosis or advised treatment.

Parent/Guardian Full Name

Relationship to Student

Signature

Date

PART III – PARTICIPATION CONSENT AND WAIVER

I understand and certify that my child's participation in any workshop, class, field trip or program is completely voluntary. I understand that in addition to instruction time inside of the Bravo School of Art studio, students may walk to the NTC Park and be given supervised recreational time there, and that students and staff may also walk to adjacent areas in and around the NTC campus during the session. Certain hazards and dangers are inherent in all of the above named activities, and I hereby release Bravo School of Art and its agents from any claims, demands, and causes of action as a result of my child's voluntary participation and enrollment. I understand that my child may be photographed during participation in said activities and I give my consent for pictures to be used for promotion for Bravo School of Art. I hereby give my full consent for my child to participate in the workshop, class, field trip or program at Bravo School of Art.

Parent/Guardian Full Name

Relationship to student

Signature

Date