



Release Form

(This form must be completed and returned to the director before your child begins participating.
Complete and mail to **Peninsula Metamorphic Arts & Learning, 139 Mines Road, Blue Hill, ME 04614.**)

Participant's Name _____ Birth Date _____

Please read carefully.

PHOTO RELEASE: I give Peninsula Metamorphic Arts & Learning permission to publish in print, electronic, or video format the likeness or image of my child in its promotional materials and publicity efforts without further notice to me. I understand that the photographs/video may be used in recruiting brochures, newsletters, magazines, other publications, print-ads, direct-mail pieces, electronic media, or other forms of publication. I hereby waive any right to inspect or approve the finished photographs/videos that may be used now or in the future. I release all claims against Peninsula Metamorphic with respect to copyright ownership and publication, including any claim for compensation related to use of the materials. I understand that cautionary steps will be taken to provide minimum identifying information.

- I AGREE (please sign below)**
- I DISAGREE (please sign below)**

Parent/Guardian

Date

Please read carefully.

CHILD PICK-UP: Anyone (not known by the PMAL staff) picking up your child will need to present a photo I.D. to the staff for the release of your child. We will not release your child unless proper identification is given. Please list persons (including yourself) authorized to pick-up your child. Please print clearly.

A written note signed by you will be necessary to add authorized persons to this list. While this may seem extreme, we only have the safety of your child in mind!



Medical Form

(This form must be completed and returned to the director before your child begins participating.
Complete and mail to **Peninsula Metamorphic Arts & Learning, 139 Mines Road, Blue Hill, ME 04614.**)

Participant's Name _____

Participant's Date of Birth _____ Age _____ Current Grade _____ Gender _____

Home Address _____

Mailing Address _____

Second Parent Address (if different from above) _____

Mailing Address _____

E-Mail Address _____

Emergency Contact:

Parent/Guardian Name _____

Phone _____ Work Phone _____ Cell Phone _____

E-mail address _____

Second Parent/Guardian Name _____

Phone _____ Work Phone _____ Cell Phone _____

E-mail address _____

If a parent/guardian is not available, please contact:

Name: _____ Relationship to child _____

Phone _____ Work Phone _____ Cell Phone _____

Medical History:

Special Dietary Needs _____

Does your child have any allergies, including reactions to insect bites/stings and food? (List)

Does your child have any medical conditions or restrictions that might limit his or her participation in camp activities? ____ yes ____ no If yes, please explain. _____



Does your child have any special needs or disabilities? If yes, please explain. _____

Is your child taking any medication? ____ yes ____ no If yes, please list. _____

If your child is to receive medications, use an inhaler, or needs an Epipen, please enclose a written order from your physician and send the medications in the original pharmacy-labeled container. No prescription medications will be dispensed unless they are in a pharmacy-labeled container.

Your signature below authorizes the camp director to dispense the following over-the-counter medications:

Tylenol	Advil	Benadryl (liquid and tablet)
CortAid .5% crème	Neosporin	Medicine Stingese
Hall's coughdrops	Isotonic eye irrigating solution	

Parent/Guardian _____

Date _____

Please use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health, about which Peninsula Metamorphic Arts & Learning should be aware.

Date of child's last tetanus shot _____

Family Physician _____ Phone _____

Insurance Carrier _____ Policy # _____

Insured Name _____ Insurance I.D. # _____

Permission to Provide Necessary Treatment or Emergency Care:

In the event that I cannot be reached in an emergency, I hereby give permission to Peninsula Metamorphic Arts & Learning and their staff to select a medical service provider and secure first aid and/or medical treatment for the child named above. In this same instance, I give permission to the medical services provider selected by the camp representative to secure and administer treatment, including hospitalization, for the child. I understand that this authorization includes transporting my child by ambulance if necessary to the nearest medical treatment facility or hospital if I am unable to be reached first. I agree to be personally responsible for any related medical expenses. On behalf of my child and myself, I release Peninsula Metamorphic Arts & Learning, its agents, and employees from any liability arising out of medical treatment obtained.

Parent/Guardian _____

Date _____