Homeschool Consent Form

PART I EMERGENCY CONTACT INFORMATION

Parent Name ________________________________ Day Phone ___________________ Alt. Phone ____________
Alternate Contact ____________________________ Relationship to child _________________________
Day Phone ___________________ Alt Phone ____________

PART IIA ALTERNATIVE DEPARTURE

I grant permission for my child(ren) to leave with the following adult guardians other than myself:
Name: _____________________________ Phone: _______________________ Relationship: ________________
Name: _____________________________ Phone: _______________________ Relationship: ________________

PART IIB ALTERNATIVE

I grant permission for my child(ren) to leave the museum unaccompanied (either by walking or taking public transportation) at the end of the Workshop sessions:

O Yes, I do. O No, I do not.

PART III PHOTO RELEASE

I grant permission for my child(ren) to be photographed anytime during the Homeschool Workshops Series. I fully understand that these photos may be used for informational, educational, and/or promotional pieces.

O Yes, I do. O No, I do not.

PART IV HEALH HISTORY

Complete only if attending your 1st Homeschool workshjop at TFI.

As we sometimes do activities where students may, go outdoors, eat the product, or be involved in some physical activity, we are requesting that you complete the following information so that we may ensure that appropriate conditions are provided for all students. You do not need to have your child examined by a physician, but please complete this information using your most recent medical records. Please complete a separate form for each child. Thank you!

Child's Name ____ Age During Workshop ___________

Check the session(s) your child will attend:

O *Brainiacs: Unlocking the Mysteries of the Brain* **O** *Eww That's Gross: Chemistry of the Digestive & Excretory Sys.*

Check any condition that applies, and elaborate if necessary:

O hay fever	O poison ivy, oak, etc.	O allergies	O diabetes	O asthma	O ear infection
O food (list below)	O insect stings	O epilepsy	O medicine	O heart trouble	O other

Comments ____
Date of the last tetanus shot __________Date of last health exam _______ Operations/serious injuries (dates) _______________
Chronic or recurring illness(es) ___________________________________
Remarks (details above) ____

SPECIAL NEEDS (dietary or mobility needs and/or restrictions) ____
Current medications ____

- If there is any additional information that we should be aware of, please list below (special emotional needs, phobias, etc.)

Comments ____
____

I witness whereof and intending to be legally bound thereby:
Parent/guardian signature ____
Date ___________________________

The Franklin Institute Science Museum