

# Juilliard Summer Jazz Residency • Emergency Contact Form

Jackson Elementary School • Atlanta, GA • June 8 - 12, 2009

Residency Participant Name: \_\_\_\_\_ Gender:  Male  Female

First Middle Last

Address: \_\_\_\_\_ Apt Number

Street Address

City State

Zip Code

Home Phone Number

Cell Phone Number

Date of Birth: \_\_\_\_\_  
MM/DD/YY

## Custodial parent/guardian

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

First Middle Last

Home Address: \_\_\_\_\_ Apt Number  
(if different from above):

Street Address

City State

Zip Code

Business name and address: \_\_\_\_\_

Home Phone Number

Business Phone Number

## Second parent/guardian

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

First Middle Last

Home Address: \_\_\_\_\_ Apt Number  
(if different from above):

Street Address

City State

Zip Code

Business name and address: \_\_\_\_\_

Home Phone Number

Business Phone Number

## Emergency Contact Information:

Please list an emergency contact, other than parent or guardian, who will be available to pick up child if needed during residency

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

Relationship to residency participant: \_\_\_\_\_

Home Phone Number

Cell Phone Number

Work Phone

In the event a child needs to see a physician, the Atlanta Public School cannot be responsible for transportation to & from the doctor. The custodial parent or guardian will be notified to come and transport the child, or in the case of an emergency, the child will be transported by EMT services. In this document, "APS" means the sponsor of the activities in which the registrant engages in the school known as Jackson Elementary School. Also in this document, school property refers to instruments and equipment owned by APS or The Juilliard School.

Permission to Provide Necessary Treatment or Emergency Care: I hereby give permission to the medical personnel to order X-rays, routine tests, and treatment, to release any records necessary for insurance purposes, and to provide or arrange necessary related transportation, for me or my child. In the event my child experiences a medical emergency, and residency personnel try but fail to reach me or under the circumstances are without sufficient time to try to reach me, I hereby give permission to the physician or other medical personnel to secure and administer treatment, including hospitalization, anesthesia, surgery, and injections of medication for my child. As long as the medical treatment considered necessary in the situation is in accordance with generally accepted standards of medical practice for the particular type of injury or illness involved, I impose no specific limitations or prohibitions regarding treatment other than the following: \_\_\_\_\_

Signature of parent or guardian \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to residency participant: \_\_\_\_\_

NAME OF PARENT OR GUARDIAN (PLEASE PRINT): \_\_\_\_\_

**Insurance Information**

Is the participant covered by family medical/hospital insurance? \_\_\_\_\_

Indicate carrier or plan name \_\_\_\_\_ Group # \_\_\_\_\_

Name of insured \_\_\_\_\_ Relationship to residency participant \_\_\_\_\_

Social security number of policy holder or insurance ID number \_\_\_\_\_

**Please submit a copy – front and back of your health insurance card.**

**Does your child have a Behavior Intervention Plan (BIP) at his/her school?**  Yes  No

**Does your child take medication for behavior issues during the school year?**  Yes  No

**If yes, will he/she be taking this medication at the residency? If yes, please explain below.**  Yes  No

**Does your child have health problems?**  Yes  No

**If yes, please explain:** \_\_\_\_\_

**Please list special diet/food allergies:** \_\_\_\_\_

**Allergies:**

Hay Fever  Penicillin  Drugs  Insect Bites

Nuts: what kind \_\_\_\_\_  Asthma  Food  Other

**Please provide additional specific details** \_\_\_\_\_

**PLEASE NOTE:** Any accidents and illnesses must be reported to APS staff before the participant leaves the school each day. The residency participant is not allowed to possess any type of medicine on school grounds unless he or she has a *letter of explanation*.

Please note the medication must be in the original prescription container/bottle with the name and an explanation note from the prescribing physician. Over the counter medication should be brought in the original container with a parent note of explanation. All explanation notes and medicines should remain with the residency participant at all times. The APS and Juilliard are not responsible for monitoring and dispensing medication.

**PARENT'S/GUARDIAN'S AUTHORIZATION:** The residency participant described has permission to engage in all residency activities except as noted by me in a *separate letter*. The residency participant and his/her parent/guardian agree to abide by the rules and regulations set up by the APS for health, safety and welfare of the residency. The following violations of residency rules will result in immediate dismissal without refund of fees:

- 1) Leaving Jackson Elementary School without permission.
- 2) Willful destruction of school property.
- 3) Use of drugs and/or alcoholic beverages.
- 4) Fighting and/or continued insubordinate behavior resulting in disrupting of the residency program.

Signature Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Residency Participant's Signature \_\_\_\_\_ Date \_\_\_\_\_

# Juilliard Summer Jazz Residency • Consent Form

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## CONSENT FORM

All scheduled activities (both on & off campus) are closely supervised. Please check yes or no for each statement, and sign at bottom of page.

- I give permission for my child's name, picture, or video clips taken of my son/daughter to be used in APS/Juilliard publicity or publications.

Yes     No

- I understand that I am responsible and financially liable for the medical care of my child. In case of an emergency and I cannot be notified, the school has permission to seek medical attention for my child.

Yes     No

- I agree that I will not hold the APS and The Juilliard School responsible for any accidents, injuries or other harm occurring to my child during the residency.

Yes     No

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Signature of Parent/Guardian

Date

**Completed emergency contact form must be received *no later than May 1, 2009.***

Mail to:

Office of Jazz Studies  
The Juilliard School  
60 Lincoln Center Plaza  
New York, NY 10023

Questions? Please call Mr. Reginald Colbert (404) 802-4728