



Youth Medical Release/Permission Form

Semester: Fall Spring Summer YEAR _____

Class Title: _____

Today's Date: _____

This form must be entirely complete before the student is allowed to attend class.

NAME: _____ SEX: M F
First MI Last

Address: _____ City: _____ Zip: _____

Phone: _____ Age: _____ Birth date: ____ / ____ / ____

School: _____ Grade: _____

Parent's Name: _____ Phone (day) _____ (eve) _____

Email Address: _____

Alternate Contact: _____ Phone: _____

Please read and initial the following:

- I give consent and authorize Pacific Northwest College of Art to use my child's name, photograph and/or artwork for education and public relations purposes. Yes No Initials _____
- I give permission for my child to participate in field trips organized by the Pacific Northwest College of Art. Yes No Initials _____
- Ages 16-18 only: I give permission for my son/daughter to work from the human form (nude male/female models.) Yes No Initials _____

Mandatory Medical Information

Please check if your child/teen is subject to any of the following:

ADD/ADHD Asthma Depression Diabetes Fainting Hearing loss
Sight Loss Heart trouble Seizure disorder Other (please explain) _____

List any medications and describe the medical condition.

List any allergies to food, insects, medication, etc. Describe allergic reactions and their severity.

Physician's name: _____ Phone: _____

(OVER)

Last Name

Middle Initial

First Name

Youth Medical Release/Permission Form Continued

Mandatory Medical Information (Continued)

Describe any mental or emotional challenges.

Describe any behavioral issues that might pose a challenge to group learning (please be specific).

Please read carefully the following and initial.

Should any injury occur during or as a result of participation in any Pacific Northwest College of Art class, workshop, camp or program I agree to indemnify and hold harmless PNCA and all its employees, staff, instructors, and volunteers connected with the Pacific Northwest College of Art.

Initials _____

My child/teen has my permission to participate in all session and field trip activities. In case of emergency, I hereby request and authorize any physician, hospital and healthcare provider to provide medical treatment promptly for my child whether or not I am contacted and informed.

Initials _____

For a child/teen requiring medication: Designated PCNA staff will dispense medication under physician's orders. Under statute ORS 30.800 and 30.807 (Good Sam Act), all medications must be in a prescription container clearly labeled with child's name, type of medication, dosage, and times to administer medication to my above named child in the manner described by the physician's orders.

Initials _____

For a child/teen requiring injections: Generally PNCA staff and instructors are not trained to administer injections or other medical procedures. PNCA policy allows individual staff and instructors to voluntarily act under the statutes ORS 30.800 and 30.807 and administer requested injections or other medical procedures, should they individually choose to do so on a case-by-case basis. Instructions as to requested injections or medical procedures must be provided by the physician. I request PNCA to inquire whether there are staff or instructors who are willing to consider acting under statute ORS 30.800 or 30.807 on a case-by-case basis should my above name child need an emergency injection or other medical procedure in the manner described in the physician's orders. PNCA cannot guarantee that it will find willing staff or instructors to act under the statutes ORS 30.800 or 30.807 or that such staff or instructors will so act in every case.

Initials _____

Signature of Parent/Legal Guardian

Date