

# MURALARTSPROGRAM

## Mural Corps 2006-2007 Application

### PARTICIPANT INFORMATION

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Today's Date \_\_\_\_\_

School or Program (if any): \_\_\_\_\_ Grade in Sept 06 (if applicable): \_\_\_\_\_

Student's Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_

Parent/Guardian Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Parent/Guardian email: \_\_\_\_\_ How often do you check email? Frequently \_\_\_ Not often \_\_\_

Do you have a work permit? (Circle one) Yes No NA

### EMERGENCY CONTACT (someone other than parent/guardian)

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

Emergency Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

### MEDICAL INFORMATION (please attach current physical form)

Does the participant have any allergies or medical conditions? \_\_\_\_\_

Name of Child's physician/ medical care provider: \_\_\_\_\_

Address of physician/ medical provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Health insurance coverage for child or medical assistance benefits: \_\_\_\_\_ Policy #: \_\_\_\_\_

**Please read and sign the below permission releases. Leaving the boxes blank below implies you are giving Mural Arts authorization for these releases.**

<p><b>Trips Release</b> "I give permission for my child/ward to be transported on field trips while at the Mural Arts Program."  Parent/Guardian Initials _____ Yes___ No___</p>	<p><b>Media Release</b> "I hereby grant permission to record my child's/ward's likeness and/or voice for any use by television, film, radio, web page or printed media to further the aims of the Philadelphia Mural Arts Program in related campaigns and magazine articles, booklets, posters, and in any other way they see fit." Parent/Guardian Initials _____ Yes___ No___</p>	<p><b>Evaluation Release</b> "I hereby grant permission for my child/ward to participate in an evaluation of the program involving written questionnaires."  Parent/Guardian Initials _____ Yes___ No___</p>
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I allow my child/ward to receive emergency medical care.  
Parent/ Guardian Initials: \_\_\_\_\_ Yes\_\_\_ No\_\_\_

I allow my child/ward to receive minor first aid procedures.  
Parent/ Guardian Initials \_\_\_\_\_ Yes\_\_\_ No\_\_\_

**Parent/Guardian Signature** \_\_\_\_\_

**Send application to:**  
Mural Arts Program, Thomas Eakins House, 1729 Mount Vernon St. Philadelphia PA 19130 Attn: Shari Hersh or fax to 215.685.0757. For more information call Shari Hersh at 215-685-0753.

**Note: Enrollment is limited. Applicants will be notified about acceptance into program. Please understand more information maybe required for admission depending on program. All program are FREE of charge!**

Please note that address information may be used anonymously for geographic or statistical analysis as requested by MAP's funders.