

**The Science of Art at the African American Museum**  
**APPLICATION FORM FOR 2019 SUMMER CAMP (June 10 - July 19, 2019)**  
**Ages 8 - 15**

**Application Deadline: May 1, 2019**

Application Fee: \$10.00 Per Student    Camp Fee: \$250.00 (6 weeks)  
**FREE ADMISSION** for Students Who Qualify for Federal Lunch Assistance  
(Please complete federal assistance application)

**BACKGROUND INFORMATION:**

NAME OF STUDENT \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_

AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SEX \_\_\_\_\_

ETHNICITY/RACE (FOR STATISTICAL PURPOSES ONLY) \_\_\_\_\_

PARENT/GUARDIAN NAME \_\_\_\_\_

ADDRESS (IF DIFFERENT THAN ABOVE) \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK# \_\_\_\_\_ HOME# \_\_\_\_\_

SCHOOL ATTENDING \_\_\_\_\_ STUDENT ID# \_\_\_\_\_

**MEDICAL INFORMATION:**

PLEASE LIST SPECIAL MEDICAL CONCERNS (MEDICATIONS CURRENTLY TAKING, ALLERGY MEDICINES, SURGERIES, ETC.)

IN CASE OF EMERGENCY, PLEASE CONTACT THE FOLLOWING INDIVIDUALS:

NAME	PHONE NUMBER
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IN THE EVENT OF AN ACCIDENT, WHERE IMMEDIATE MEDICAL ATTENTION IS NECESSARY, PLEASE CONTACT MY DOCTOR AND TAKE MY CHILD TO THE HOSPITAL LISTED BELOW.

DOCTOR'S NAME \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

DOCTOR'S HOSPITAL \_\_\_\_\_

WAIVER OF CLAIM:

I, \_\_\_\_\_ OF \_\_\_\_\_  
(PARENT OR GUARDIAN) (STUDENT)

GIVE PERMISSION FOR MY CHILD TO PARTICIPATE IN THE ACTIVITIES OF THE AFRICAN AMERICAN MUSEUM.

I, ALSO HEREBY, RELEASE THE AFRICAN AMERICAN MUSEUM, THEIR STAFF MEMBERS, AND OTHER PERSONS AND ENTITIES ASSOCIATED FROM ANY LIABILITIES AND RESPONSIBILITIES FOR ACCIDENTS OR INJURIES ARISING FROM THE AFRICAN AMERICAN MUSEUM SUMMER PROGRAM AND RELATED ACTIVITIES. I HAVE READ AND UNDERSTAND THE FOREGOING CONSENT RELEASE AND WAIVER AND WAIVE ANY AND ALL CLAIMS, SUITS, AND CAUSES OF ACTIONS RELATED THERETO.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_