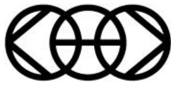

REGISTRATION AND HEALTH FORM

HOMESCHOOL PROGRAMS

To register for each month, please email: scheduler@chmuseums.org and you will receive a confirmation back if your child is registered and also an email if the program is full. For your child to attend, this form must be completed and the program fees must be paid in full each month upon arrival.

Questions? *Please call us at 803-981-9182*

Museum of York County
4621 Mt. Gallant Rd
Rock Hill, SC 29732
ATTN: Homeschool Program Registration

CHILD'S NAME: ______________________________ Birthdate:__________ Sex: ________

Address: ____________________________________ City: ______________ State ____Zip: _______

Phone (H): __________________________________ Grade in the Fall: _____School:_____________

Parent/Guardian Name: _______________________ Relationship to Child: ___________________

Address: ____________________________________ City: ______________ State ____Zip: _______

Daytime Phone: ________________________Cell Phone: __________________________________

Email Address: ____

Parent/Guardian Name: _______________________ Relationship to Child: ___________________

Address: ____________________________________ City: ______________ State ____Zip: _______

Daytime Phone: ________________________Cell Phone: __________________________________

Email Address: ____

Alternate Emergency Contact: ________________________ Relationship to Child: ______________

Address: ____________________________________ City: ______________ State ____Zip: _______

Daytime Phone: ________________________Cell Phone: __________________________________

Email Address: ____

HEALTH HISTORY

Please indicate if the child has had a history of:		YES	NO	**Are there any activities that are either encouraged or discouraged by your physician?**	
	Heart Defect/Disease				
	Convulsions				
	Diabetes				
	Bleeding/Clotting Disorders				
	Psychiatric Treatment				
	Asthma			**Any disabilities or recurring illnesses?**	
	Hayfever				
Allergies to:	Poison Ivy				
	Insect Stings				
	Penicillin				
	Other Drugs			**Is tetanus booster within last ten years?**	
	Any Food			YES	NO
Doctor's Name:				**Doctor's Phone:**	

Please turn over to complete the form.

WAIVER and RELEASE; and media usage Permission

If my child/ward should require minor or major medical treatment during the course of participation in museum activities, I give my permission to the Culture & Heritage Museums and/or medical staff which they may appoint to carry out any necessary treatment and to arrange transportation for my child/ward to the emergency room of the nearest hospital, if necessary, for the administration of treatment. I understand that I will be responsible for all costs incurred in any such emergency.

I, the undersigned parent/guardian hereby freely and knowingly waive and release the Culture & Heritage Museums, its agents and organizers, and will hold them harmless, from any and every liability and responsibility for personal injury, death, damage to property, or other loss sustained by the participant as a result of or arising out of the child's participation in any activity conducted by the Culture & Heritage Museums. I assume all risks and hazards incidental to the conduct of the activity.

The health history is correct to the best of my knowledge, and the person therein described has permission to engage in all museum activities except as noted.

As the parent/guardian of the above participant, I consent to the use of videotaped footage and/or photographs of the participant, and/or use of any remarks by the participant for use on any promotional materials or proper and legitimate educational and/or commercial purposes by the Culture & Heritage Museums.

Signature of Parent/Guardian: ________________________________ Date: ____________________

Please note that the form will be returned if incomplete.

Cancellations/Refunds: There are no refunds given for cancellations.

For internal use only:
Date received: ____________________ Reviewed by: _________________________________