Spark MEDIA PROJECT

42 Catharine Street, Suite C-200
Poughkeepsie, NY 12601

Phone: 845.485.4480 E-mail: info@sparkmediaproject.org

EMERGENCY CONTACT AND TRANSPORTATION FORM

Student Name:_____

Date of Birth:_____ Age:_____ Gender: M/F

How will this student be getting home everyday?

_____Walking
_____Getting a ride
_____Public transportation
_____ (please explain):

Emergency Contact Information:

Contact Name: _____

Relationship to Student:_____

Cell phone: _____ Home phone: _____

Contact email: _____

Parent/guardian signature: _____

Date: _____

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General Release

1. I, the undersigned, being of legal age, hereby grant to Spark Media Project, its subsidiaries, employees, affiliates, and entities under common ownership, management and control with it the absolute right and permission to copyright, use, publish, reproduce, broadcast, telecast, web cast and/or cablecast my name and full content of the video project in which I participate in perpetuity for advertising, business, or any other lawful purpose whatsoever throughout the world. I furthermore grant the same permission with regard to any sound recordings, still photographs, video recordings or other images made of me by others.

2. I understand that in proceeding with the above; Spark Media Project does so in full reliance on the foregoing permission.

3. I hereby release Spark Media Project from and against any and all claims, damages, liabilities, costs and expenses that may arise as a result of the use of such information.

4. I hereby waive any right I may now or hereafter have to any residuals, reuse and/or other fees or compensation of any kind by reason of Spark Media Project's use of the above- mentioned information.

NAME OF GUARDIAN_____ **SIGNATURE**_____
DATE_____

I the undersigned am the parent and/or legal guardian of the minor named below. I have read the above Release, am fully familiar with its contents and hereby consent to its execution by the minor named below via my signature below.

Name and Address of Legal Guardian: (Please print)

_____

_____

_____

Signature_____ **On behalf of**_____

Date_____ **(Name of Minor)**

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MEDICAL RELEASE FORM

As the parent/legal guardian of _____I hereby authorize Spark Media Project and appointed staff thereof to admit, during my absence, the above-named student to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named student.

Student's DOB: _____ SS#_____

Any known allergies? yes____ no_____ If yes, please specify:_____

Any other medical conditions which should be noted? yes___ no___

If yes, please specify:_____

Currently taking medications? yes___ no___ If yes, please specify:_____

Family Physician:_____ _

Physician's Phone: _____ Insurance Provider:_____ Policy #_____

Name of Parent/Guardian _____

Parent/Guardian's Emergency Phone#_____

Signature_____Date_____