

# REGISTRATION FORM

Our Vision, Our Voice - Spring 2021

Name \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ Zip \_\_\_\_\_

Grade \_\_\_\_\_ School Name \_\_\_\_\_ School ID # \_\_\_\_\_

Parent/Guardian(s) \_\_\_\_\_

Phone numbers: Home \_\_\_\_\_ Work \_\_\_\_\_

Parent Cell \_\_\_\_\_ Student Cell \_\_\_\_\_

Parent email \_\_\_\_\_

Student email \_\_\_\_\_

Your child's teacher will contact you with each week's activities.

Do you prefer voice call, text, or email? \_\_\_\_\_

When is the best time to reach you directly? \_\_\_\_\_

PLEASE let us know if ANY of your contact information changes!

We agree to the following :

1. My child will attend all 7 meetings of Our Vision, Our Voice on Fridays from 4pm-6pm, April 30-June 11, 2021 and all 3 meetings on Saturdays from 10am-12pm, May 1, May 15, and May 29. If my child is unable to attend due to illness or a family emergency, I will call or text the teacher (phone number will be provided).
2. My child is prepared to spend 1-2 hours each week, outside of class time, to create content for the magazine (interviews, photos, poems, drawings etc.)
3. I (or a designated person) will provide prompt transportation at the end of all Our Vision, Our Voice meetings. Note: Bus passes will be provided by Flower City Arts Center if your child needs to take the RTS bus.
  - I (or a designated person) will pick up my child promptly at FCAC at 6pm on Fridays and 12pm on Saturdays
  - My child will carpool with \_\_\_\_\_
  - My child will take the RTS bus. There is a Monroe Ave. bus stop directly across the street.
4. My child will NOT sign up for any school activity which requires attendance on Fridays, 4pm-6pm, or Saturdays, 10am-12pm, during the time frame of April 30- June 11, 2021.

Students Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

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## EMERGENCY CONTACTS

RELATIONSHIP	NAME	ADDRESS	PHONE #
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## MEDICAL INFORMATION

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Health Insurance Carrier \_\_\_\_\_ Insurance # \_\_\_\_\_

Medical Conditions \_\_\_\_\_

Medications \_\_\_\_\_

Other Special Concerns \_\_\_\_\_

### Participation Consent for Your Child

I consent to enrolling my child in Our Vision, Our Voice, a program of Flower City Arts Center (FCAC), 713 Monroe Ave. I give consent for my child to use the facilities at FCAC. I waive and release any and all rights and claims or damages I may have against FCAC staff, teachers, volunteers and their representatives, successors, and assigns for any and all injuries which may be suffered by my child. In case an accident occurs and I or a designated person can not be reached, I give my permission for emergency personnel to be summoned to provide treatment.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

We ask for the following info because funders want to know who we are serving in order for us to receive grants. Your personal info will NEVER be released and will be kept in the strictest confidence.

### Household income and size

- Under \$10,000     \$10,000-14,999     \$15,000-24,999     \$25,000-34,999     \$35,000-44,999
- \$45,000-54,999     \$55,000-64,999     over \$65,000

Number of people in household \_\_\_\_\_

### Race/Ethnicity

- Black/African-American     Hispanic/Latino     Native-American     White     Asian/Pacific Islander
- Multi-Racial     Other \_\_\_\_\_

# REGISTRATION FORM

## COVID-19 ATTESTATION

I will inform my child's teacher, and not send my child to Our Vision, Our Voice if they have experienced any of the following symptoms in the 24 hours before a meeting: Fever, Fatigue, Cough, Sneezing, Aches and Pains, Runny or Stuffy Nose, Sore throat, Diarrhea, Vomiting, Headaches, Shortness of breath.

I will inform my child's teacher, and not send my child to Our Vision, Our Voice if they have tested positive for COVID-19 and understand that they can not return until they have tested negative and it has been a week since their last symptom.

I will inform my child's teacher, and not send my child to Our Vision, Our Voice if they have recently been in close contact with anyone who has exhibited any symptoms of COVID-19.

I will inform my child's teacher, and not send my child to Our Vision, Our Voice if they have recently been in close contact with anyone who has tested positive for COVID-19.

I will inform my child's teacher, and not send my child to Our Vision, Our Voice if they have traveled to a state currently under a health advisory from New York state or a country under a U.S. government advisory within 14 days of a meeting.

My child will wear a face mask for the entirety of the time they are at Our Vision, Our Voice. If they do not have a mask I will inform their teacher so we can provide them with one.

I give consent to Flower City Arts Center staff, and Our Vision, Our Voice's contract teachers to take my child's temperature upon arrival. I understand that if my child's temperature is above 100.4 they will not be allowed to attend that day's meeting.

Students Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

# STUDENT PHOTOGRAPHS AND WRITING LIMITED USE AGREEMENT

Each student in Our Vision, Our Voice will take home several copies of their own zine as well as a copy of every fellow participants' zine created containing their writing and photographs. Their zines are made possible through funding and business support. Some copies of their zines may be used to seek donations for the program.

We ask that each parent/guardian and child sign the following agreement to give permission for limited use of photographs of their child and to protect the childrens' rights to their artistic work, while authorizing the use of their work and images in their zines.

- 
1. I (parent/guardian), \_\_\_\_\_ give permission for pictures of my child to be included in the printed zines created throughout Our Vision, Our Voice and used for other promotional purposes.
  2. I (parent/guardian), \_\_\_\_\_ authorize the use of my child's artistic work in zine format which will be distributed for free or used to seek donations for the Our Vision, Our Voice program.
  3. There will be no additional compensation to my child but any donations received will be used solely to support Our Vision, Our Voice by Flower City Arts Center, a not for profit organization.
  4. The photographs and writings by my child will be credited to my child.
  5. Select photos may be used for promotion of Our Vision, Our Voice, all other rights to the work remain with my child.

Student Name (printed) \_\_\_\_\_

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Name (printed) \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

# ABOUT ME

(To be completed by program participant)

Name \_\_\_\_\_ Favorite Color: \_\_\_\_\_

1. Why do you want to join Our Vision, Our Voice? \_\_\_\_\_

\_\_\_\_\_

2. What do you want to learn? \_\_\_\_\_

\_\_\_\_\_

3. What kinds of topics will you consider including in your zine?

- arts       nature       health       poetry       fashion/beauty       community  
 news       sports       animals       careers       events       social issues

other: \_\_\_\_\_

4. Have you always lived in Rochester?

yes  no If not, where were you born? \_\_\_\_\_

5. How do you learn best?

- When I can talk about my ideas, speak, and listen to others  
 When I can look at things like pictures and take notes  
 When I can move around and use my hands

6. Do you have any special talents?

yes  no If yes, what are they? \_\_\_\_\_

7. What's your favorite class in school? \_\_\_\_\_

8. What do you like to do in your free time? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

9. Do you participate in any other activities outside of school?

yes  no If yes what are they? \_\_\_\_\_

\_\_\_\_\_

10. Name 3 types of work or careers are you interested in:

(1) \_\_\_\_\_ (2) \_\_\_\_\_ (3) \_\_\_\_\_

11. Have any friends of yours signed up for Our Vision, Our Voice?

yes  no If yes, please write their names: \_\_\_\_\_

\_\_\_\_\_