Teen Artist Internship Program Parental Consent Form

Dear Parent/Guardian,

As a parent or guardian, you are asked to consent for your daughter/son to participate in this program. This form will serve as a waiver and consent for your child to travel to his/her selected artist/mentor’s studio and work with them for at least 4 hours per week for the time period**: November 19, 2018 – March 11, 2019.**  All of the artist/mentors are practicing artists, and are residents of our community. They all have been interviewed by the NBAM/ArtWorks! staff and have had criminal background checks performed. If you have any questions, please contact me at NBAM/ArtWorks! or feel free to contact artist/mentor directly.

Additionally, NBAM/ArtWorks! continually documents programs and events for the purpose of publicity and fundraising. This form will also act as a model release authorizing NBAM/ArtWorks! to include your daughter/son in any photography in order to document this internship.

**Please make sure that this form is brought to the Orientation Meeting on**

**November 15, 2018; Thursday, 5pm at the New Bedford Art Museum,**

**608 Pleasant St. New Bedford, MA. Thank you.**

Student Name: \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Guardian Name:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY/MEDICAL CONTACT**

Student Name:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all allergies, medications, or health conditions:

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