Print name of participant: _____

Name of Program: _____ Dates covered: _____

AUDIO/VISUAL RELEASE: I understand that UD Department of Music may, from time to time, take audio or visual recordings (photographs, video, audio recordings, etc.) of my child participating in UD Dept. Of Music programs. I allow UD Dept. of Music and the University of Delaware to use these audio or visual recordings for publicity purposes without identifying my child and without compensation to me. I waive the right to inspect or approve the finished recordings and/or publication use.

YES _____ NO_____

Please circle "yes" or "no" and initial

My child is 14 years or older. I give permission for my child to arrive alone, sign him/herself in and out and may leave on their own at the end of the program. I understand this means that it is my child's responsibility to report directly to and from the lesson/program/rehearsal with little or no supervision from CMS staff.

YES _____ NO_____

Please circle "yes" or "no" and initial

LIABILITY RELEASE & PERMISSION TO PARTICIPATE

_____has my permission to participate in classes, camp, lessons and/or workshops through the University of Delaware Community Music School (UDCMS). I understand there are risks to participation and that the student in this program participates at his/her own risk.

I hereby release the UDCMS and the University of Delaware from responsibility and liability for any injury or illness that my child may sustain during CMS activities. I recognize that while attending this program, medical treatment on an emergency basis may be necessary for my child, and I further recognize that UDCMS staff may be unable to contact me for my consent for emergency medical care. In the event of an emergency, I hereby authorize an adult chaperone of these activities, as an agent for me, to consent to an x-ray examination; medical, dental or surgical diagnosis; treatment; and hospital care advised and supervised by a physician or dentist licensed to practice under the laws of the USA where the services are rendered, either at a physician's office, outpatient facility, or in a hospital, and that I will be responsible for the expenses of such care. I expect to be contacted as soon as possible.

Signature of parent/legal guardian: _____ Date_____

Printed Name of parent/legal guardian completing the form:

_____