Saturday Art Therapy Workshop
General Information Form
Child/Youth Application (Must be at least 5)

Child's Name _____ Birthdate _____ Age____
Parent's/Guardian's Names _____
Address _____City_____Zip_____
Email_____
Daytime Phone_____Cell/Alternate Phone _____
Reason for enrolling?_____
Special skills/interests _____
School _____
Permission to request school records_____Yes_____No Is child receiving medication? _____ If so, what kind? _____ Session preferred: _____ Individual _____ Group

I understand that my child and his/her art work made during the art therapy sessions may be photographed or videotaped for educational purposes only. My child will not be identified by name during this process.

Parent or Guardian Signature _____

Name of person who will be picking up client (if applicable)_____

WAYNE STATE UNIVERSITY, COLLEGE OF EDUCATION
ART THERAPY PROGRAM
RELEASE AND HOLD HARMLESS AGREEMENT

In consideration of being allowed to participate in the Art Therapy Program conducted by the Wayne State University College of Education, the undersigned, individually and as parent and/or guardian of the minor child_____ , for his/her heirs, executors, administrators and assigns, hereby expressly stipulates and agrees to release, discharge, indemnify and forever hold harmless Wayne State University, its assigns, agents, officers, Board of Governors, servants, and employees from any and all actions, claims, liabilities, damages, losses or injuries of any nature whatsoever now existing or which may hereafter be sustained by the said minor _____ in connection with his/her participation in any and all activities of the Art Therapy Program at Wayne State University.

This release extends, applies to, covers, and includes all unknown, unforeseen, unanticipated and unsuspected injuries, damages, losses, and/or liabilities, and the consequences thereof, as well as those now disclosed and known to exist. The provisions of any state, federal, local, or territorial law or statute providing in substance that releases shall not extend to claims, demands, injuries, or damages which are unknown or unsuspected at the time to the person executing such release, are expressly waived.

_____	_____
Signature (Parent or Guardian)	Signature (Parent or Guardian)
_____	_____
Printed Name	Printed Name
_____	_____
Address	Address
_____	_____
City/State/Zip	City/State/Zip
_____	_____
Witness	Witness

Return to:
Wayne State University Art Therapy Program
C/O R. Konarzewski
5425 Gullen Mall 2 North Detroit, MI 48202
FAX 313.577.4091 • EMAIL ab7419@wayne.edu

Payment Received	Date	Amount	Method