The Legacy Program: RESIDENCY

Child Registration Form

To be completed by a parent or guardian

CYCLE (7) SEVEN

Date:______________________________

Last Name: ________________________

First Name: ________________________

DOB: ______________________________

Street Address: ____

City: _______________________ State: ______ Zip: __________ Cell Phone: ________________

Home Phone: __________________________ Email: ___________________________________

PARENT/GUARDIAN INFORMATION:

Parent/Guardian Name: ____

Parent/Guardian Cell Phone: __________________________ Work Phone:__________________

Parent/Guardian Email: ______________________________

Parent/Guardian Name: ____

Parent/Guardian Cell Phone: __________________________ Work Phone:__________________

Parent/Guardian Email: ______________________________

EMERGENCY INFORMATION: Please enter two contacts other than parents/guardians.

Emergency Contact: __________________________ Relationship: ____________________________

Emergency Contact Immediate Access Phone Number: ______________________________________

Emergency Contact: __________________________ Relationship: ____________________________

Emergency Contact Immediate Access Phone Number: ______________________________________

MEDICAL INFORMATION:

Please list any chronic or acute medical conditions affecting your health:

____
____
____
____

Please list any allergies you have:

____
____

Is your child in adequate health to participate in the activities of The Legacy Program? _________ Yes __________ No

Does your child have his/her own health insurance? ________Yes _________No

If 'Yes', please list your child's insurer here: ______________________________

PARENTAL CONSENT: *(To be completed by a parent - Initial each applicable line below)*

______ I understand and give permission for my child to be involved in a genealogical search of his/her maternal and/or paternal family lineage, and that his/her findings will be exposed to The Continuum Project staff, other participants and the community at large.

______ I understand and give permission for my child to engage in DNA ancestry testing by African Ancestry, Inc. I understand that the results will expose his/her geographic location and ethnicity of African ancestral heritage for one family line according to guarantees made by African Ancestry, Inc. (Unwillingness to participate in ancestry testing will disqualify your child from participating in the program.)

______ I understand and give permission for the results of my child's ancestry test to be announced for the first time before the audience of my child's culminating performance.

______ I understand that the genealogical and ancestral information gathered will be used to create a theatrical presentation to be performed by participants for the community.

______ I understand that my child's unearthed genealogical and genetic information may be used in the creation of professional work which may include, but not be limited to, plays (published and performed for the stage), photography, documentaries, films, literature, and video. I understand that the details of my child's and family information will be changed for these works and that they will be the sole property of The Continuum Project, Inc. I understand that I will have no financial claim on properties created.

_______ Initial here if you do not want your unearthed information to be used for the creation of professional work.

Check one option below to determine which ancestral test your child will take:

______ MatriClan Test (tests maternal African ancestry) ______ PatriClan Test (tests paternal African ancestry)

DISMISSAL INFORMATION:

Parent/Guardian Full Legal Name: ____

Parent Cell Phone Number: __________________ Parent Email Address: _________________

Additional Dismissal Authorizations:

I hereby authorize my child, ______________________, to be dismissed in the custody of:
(Please list the legal names of those individuals other than parents and emergency contacts with whom we can release your child. Note: the person will be required to submit NY state issued identification for verification. Please write "SELF" if the young person is allowed to leave our authority on their own recognizance. If your child is not authorized to be released to anyone, please write "NONE" on each line below.)

1. ________________________________

2. ________________________________

Please sign below to validate that all information gathered on this registration form is, to your knowledge, true and accurate. Please note that your signatures indicate that the participant is willing and able to commit to the outlined schedule for the program (listed below).

Participant Signature: ___________________ Parent Signature: ________________________

LPC7 DATES:

DATES TBA

TIMES:

3:15 - 5:30PM

LOCATION:

WILLIAM ALEXANDER MIDDLE SCHOOL

350 5TH AVENUE, RM 309

BROOKLYN, NY

The Legacy Program is a theatre arts education, youth development initiative in which participants synthesize the study of personal genealogy and genetics into a theatrical experience of self-discovery. At the close of their culminating performance, participants receive the results of their African ancestry test, thus learning the probable place of their African ancestral heritage for the first time.

Orientation is on Sept. 27th!

Teacher nomination and parent approval is required for participation