

FORT WORTH MUSEUM OF SCIENCE AND HISTORY  
**FWMSH LITTLE SCHOLARS PROGRAM STUDENT INFORMATION**

Please print. All sections must be completed. This information is confidential.

Student Last Name \_\_\_\_\_ Student First Name (the one they go by) \_\_\_\_\_

This student is enrolled in \_\_\_\_\_ school in the \_\_\_\_\_ grade.

Does student have a personal or school-issued computer to use for virtual work at the FWMSH Little Scholars Program? ( ) No ( ) Yes

Does this student receive special services through FWISD? ( ) No ( ) Yes - Please list those services here:  
\_\_\_\_\_

Allergies? (food or other) ( ) No ( ) Yes - Please be specific \_\_\_\_\_

Will student be bring an EPI Pen to class? ( ) No ( ) Yes (If yes, please submit the attached FARE Allergy Action Plan with this form.)

Any other medications taken on a regular basis? ( ) No ( ) Yes - Please list medications and dosages here:  
\_\_\_\_\_

Would you like to share any other medical needs, or diagnosis? ( ) No ( ) Yes - Please be specific  
\_\_\_\_\_

Is student carpooling with other student/s? ( ) No ( ) Yes \_\_\_\_\_

Does your child identify as ( ) White ( ) Black or African American ( ) Asian  
(optional) ( ) Native Hawaiian or Pacific Islander ( ) Other

What is the primary language spoken at home? \_\_\_\_\_

**EMERGENCY CONTACTS:** Provide two additional emergency contacts to call if the parent(s)/guardian(s) cannot be reached.

First & Last Name \_\_\_\_\_ Phone Number \_\_\_\_\_ Relationship to student \_\_\_\_\_

First & Last Name \_\_\_\_\_ Phone Number \_\_\_\_\_ Relationship to student \_\_\_\_\_

**CHILD RELEASE:** Children will only be released to a parent(s)/guardian(s) listed on the application, the emergency contacts listed above or to a person designated below after verification of ID. I authorize The Fort Worth Museum of Science and History to release my child to ONLY with the following persons. There will be no exceptions.

First & Last Name \_\_\_\_\_ Phone Number \_\_\_\_\_ Relationship to student \_\_\_\_\_

First & Last Name \_\_\_\_\_ Phone Number \_\_\_\_\_ Relationship to student \_\_\_\_\_

First & Last Name \_\_\_\_\_ Phone Number \_\_\_\_\_ Relationship to student \_\_\_\_\_

**MEDICAL AUTHORIZATON** In the event I cannot be reached to make arrangements for emergency medical care, I authorize the Fort Worth Museum of Science and History Museum School to take my child to Cook Children's Medical Center. I authorize the Fort Worth Museum of Science and History to secure any and all necessary emergency medical treatment and transport for my child.

Parent/Guardian Signature \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_