SAIC CONTINUING STUDIES

School of the Art Institute of Chicago
Continuing Studies
36 South Wabash Avenue, suite 1201
Chicago, IL 60603
Email: cs@saic.edu
Phone: 312.629.6170 Fax: 312.629.6171

Middle School Program (MSP) Registration Form

☐Fall ☐Spring ☐Summer Year: 20 _____

STUDENT INFORMATION ***(PLEASE COMPLETE ALL FIELDS AND PRINT CLEARLY)***

I am : ☐ A New SAIC student ☐ A Returning SAIC student

Last Name | First Name | Preferred Name | MI | ID # (if returning)

Address | Apartment

City | State | Zip Code | Date of Birth (MM/DD/YYYY)

Primary Email Address (**confirmation will be sent here)** | Primary Phone: ☐ Mobile ☐ Home ☐ Work | Secondary Phone: ☐ Mobile ☐ Home ☐ Work

School Name/Type: ☐Public ☐Home School ☐Parochial ☐Private/Independent ☐Charter/Magnet | Grade | HS Grad Year

Please note: Text messages may be sent to phone numbers.

Note: If your student has a medical/health condition or disability that may require emergency/classroom assistance, please complete the Allergy History Form and/or Emergency Action Plan form available in the Forms and Downloads section of the website, or email cs@saic.edu with details.

PARENT/GUARDIAN INFORMATION (All fields required)

Last Name | First Name

Relationship to student

Email Address

Phone: ☐Mobile ☐Home ☐Work

EMERGENCY CONTACT INFORMATION (Additional contact other than primary required)

Last Name | First Name

Relationship to student

Email Address

Phone: ☐Mobile ☐Home ☐Work

OPTIONAL

Do you consider yourself to be Latino/Hispanic? ☐ Yes ☐ No

In addition, select one or more of the following racial categories to describe yourself: ☐ Native American ☐ Asian ☐ Black or African American ☐ Native Hawaiian ☐ White

How did you hear about us?

☐ Brochure ☐ Email ☐ Friend ☐ I am a returning student ☐ The Art Institute of Chicago ☐ SAIC Website ☐ Teacher ☐ Other _____

COURSE SELECTIONS

Class number | Title | Class dates | Day(s) | Meeting times

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Class number | Title | Class dates | Day(s) | Meeting times

ARTICARD (Student ID)

All students will receive an ARTICard, SAIC's mandatory identification card. This card permits access to School facilities and the Art Institute of Chicago museum, and must be worn at all times. Students who send in the required items will receive their ID on the first day of class. Students who are unable to attend the first day should still send in their photo for an ID. Please visit **tinyurl.com/CS-articard** for details, and **tinyurl.com/articardFAQ** for info.

CONTINUING STUDIES ACKNOWLEDGMENT + AGREEMENT

Registration/Cancellation: I understand that I am financially responsible for the course(s) for which I am registering. A full refund will be granted for cancellations submitted **in writing or in person one week before the class**. ***I agree to the foregoing on behalf of myself/my child or ward***. I acknowledge that I will be required to follow SAIC's evolving policies around masking, social distancing, and submission of vaccine status documentation. I understand that if I do not adhere to these policies, I will be at risk of being withdrawn from the program without a refund.

X

Signature required of student or parent/legal guardian if student is under 18 years of age. | Date

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THE JOANNE ALTER SCHOLARSHIP

The Joanne Alter Scholarship is a merit–based fund that will benefit one Middle School Program student each fall and spring semester. The scholarship will cover 100% tuition for the ten–week course.

APPLICATION REQUIREMENTS:

1. Two examples of the student's most recent work—email to ***cs@saic.edu*** and include Joanne Alter Scholarship in the subject line.

   Only digital images of work sent via email will be accepted.

2. A letter of recommendation from student's middle school or SAIC art instructor.

   If you need assistance obtaining a letter of recommendation, contact Continuing Studies at **312.629.6170 or email **cs@saic.edu**.*

3. A brief essay indicating why the student would like to enroll in the course, and how they would benefit from it (one page maximum).
4. Completed Middle School Program and Joanne Alter Scholarship Application Form, signed by parent.

THE JOANNE ALTER SCHOLARSHIP APPLICATION FORM

CONTACT INFORMATION *(PLEASE COMPLETE ALL FIELDS AND PRINT CLEARLY)* ☐Fall

Last Name _____ First Name _____ Preferred Name _____ MI _____

Address _____ Apartment _____ ☐Spring Year: 20 _____

City _____ State _____ Zip Code _____ Date of Birth (MM/DD/YYYY) _____ ID # (if returning) _____

Parent Email Address _____ Student Email Address _____ Primary Phone: ☐ Mobile ☐ Home ☐ Work _____ Secondary Phone: _____

ADDITIONAL INFORMATION

Size of Household: _____ How many in college? _____

Are there any other family members applying for financial aid from SAIC? ☐ No ☐ Yes If yes, how many? _____

Have you previously received financial assistance from SAIC? ☐ No ☐ Yes If yes, when? _____

Accommodations for Students with Disabilities

The School of the Art Institute of Chicago is committed to providing opportunities for full participation in all programs for students with disabilities, including Continuing Studies students and Students At Large. Disabled students should first contact the Disability and Learning Resource Center (DLRC) to request reasonable accommodations. To plan for the most effective accommodations, we ask that you contact the DLRC at least two weeks before the start date for your course. For more detailed information about the DLRC and the accommodations process, see https://www.saic.edu/life-at-saic/wellness-center/disability. The DLRC can be reached by phone at 312- 499-4278 or email dlrc@saic.edu.

X _____ _____

Parent's signature (parent/legal guardian must sign if the student is under 18 years of age) Date

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ALLERGY HISTORY & INFORMATION FORM

Complete this form only if your child has an allergy that may require emergency assistance. If emergency medication may be required while your child is at SAIC, an Emergency Action Plan (EAP) form must be completed by your child's physician and submitted prior to the start of class. SAIC staff members are not able to administer emergency medication without a completed Emergency Action Plan on file from your child's physician.

STUDENT NAME (PLEASE PRINT):	**ID NUMBER:**

ALLERGENS:
WHEN AND HOW DID YOU FIRST BECOME AWARE OF THE ALLERGY?
WHEN WAS THE LAST TIME YOUR CHILD HAD A REACTION?
PLEASE DESCRIBE THE SIGNS AND SYMPTOMS OF THE REACTION:
WAT MEDICAL TREATMENT WAS PROVIDED, AND BY WHOM?

SAIC staff members are not trained medical professionals. However, they have been trained to administer EpiPens in the event of an emergency. For students enrolled in the Children's Workshops, parents are required to provide SAIC with an EpiPen to be stored on-campus for the duration of their child's class. The EpiPen must be clearly marked with the child's name. For Middle School and Early College Program students, SAIC expects that the students will carry their own medication.

SAIC staff members will only administer medication in the event of an emergency. All other non-emergency medication should be self-administered or be arranged to be administered by parents.

Please note that SAIC staff are not able to administer over-the-counter (non-prescription) medication, even if a physician indicates use of said medication in the student's Emergency Action Plan (EAP). If non-prescription medication is indicated on a student's EAP, parents will be asked to follow up with their physician to update the form.

PARENT/GUARDIAN NAME (PLEASE PRINT):	**PARENT/GUARDIAN SIGNATURE:**	**DATE:**

ILLINOIS FOOD ALLERGY EMERGENCY ACTION PLAN AND TREATMENT AUTHORIZATION

CHILD'S PHOTOGRAPH

NAME: _____ **D.O.B:** _____

TEACHER: _____ **GRADE:** _____

ALLERGY TO: _____

ASTHMA: ☐ **YES (HIGHER RISK FOR A SEVERE REACTION)** ☐ **NO** **WEIGHT:** _____ **lbs**

ANY SEVERE SYMPTOMS AFTER SUSPECTED INGESTION:

LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue)

Or COMBINATION of symptoms from different body areas:

SKIN: Hives, itchy rashes, swelling
GUT: Vomiting, crampy pain

INJECT EPINEPHRINE IMMEDIATELY

- Call 911
- Begin monitoring (see below)
- Antihistamine
- Inhaler (bronchodilator) if asthma

Inhalers/bronchodilators and antihistamines are not to be depended upon to treat a severe reaction (anaphylaxis)➔use Epinephrine

When in doubt, use epinephrine. Symptoms can rapidly become more severe.

MILD SYMPTOMS ONLY:

MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Vomiting, crampy pain

GIVE ANTIHISTAMINE

- Stay with child, alert health care professionals and parent.

IF SYMPTOMS PROGRESS (see above), INJECT EPINEPHRINE

☐ **If checked, give epinephrine for ANY symptoms if the allergen was likely eaten.**
☐ **If checked, give epinephrine before symptoms if the allergen was definitely eaten.**

MEDICATIONS/DOSES

EPINEPHRINE (BRAND AND DOSE): _____

ANTIHISTAMINE (BRAND AND DOSE): _____

OTHER (E.G., INHALER-BRONCHODILATOR IF ASTHMA): _____

MONITORING: Stay with the child. Tell rescue squad epinephrine was given. A second dose of epinephrine can be given a few minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping child lying on back with legs raised. Treat child even if parents cannot be reached.

☐ **Student may self-carry epinephrine** ☐ **Student may self-administer epinephrine**

CONTACTS: Call 911 Rescue Squad: _____

Parent/Guardian: _____ Phone: _____

Name/Relationship: _____ Phone: _____

Name/Relationship: _____ Phone: _____

LICENSED HEALTHCARE PROVIDER SIGNATURE: _____ Phone: _____ Date: _____
(REQUIRED)

I hereby authorize the school district staff members to take whatever action in their judgment may be necessary in supplying emergency medical services consistent with this plan, including the administration of medication to my child. I understand that the Local Governmental and Governmental Employees Tort Immunity Act protects staff members from liability arising from actions consistent with this plan. I also hereby authorize the school district staff members to disclose my child's protected health information to chaperones and other non-employee volunteers at the school or at school events and field trips to the extent necessary for the protection, prevention of an allergic reaction, or emergency treatment of my child and for the implementation of this plan.

Parent/Grardian Signature: _____ Date: _____

DOCUMENTATION

- Gather accurate information about the reaction, including who assisted in the medical intervention and who witnessed the event.
- Save food eaten before the reaction, place in a plastic zipper bag (e.g., Ziploc bag) and freeze for analysis.
- If food was provided by school cafeteria, review food labels with head cook.
- Follow–up:
    - Review facts about the reaction with the student and parents and provide the facts to those who witnessed the reaction or are involved with the student, on a need-to-know basis. Explanations will be age-appropriate.
    - Amend the Emergency Action Plan (EAP), Individual Health Care Plan (IHCP) and/or 504 Plan as needed.
    - Specify any changes to prevent another reaction.

TRAINED STAFF MEMBERS

Name: _____ Room: _____

Name: _____ Room: _____

Name: _____ Room: _____

LOCATION OF MEDICATION

☐ STUDENT TO CARRY

☐ HEALTH OFFICE/ DESIGNATED AREA FOR MEDICATION

☐ OTHER: _____

ADDITIONAL RESOURCES

Ann & Robert H. Lurie Children's Hospital of Chicago
800-KIDS-DOC
https://www.luriechildrens.org

Food Allergy Research and Education
800-929-4040
http://www.foodallergy.org

This document is based on input from medical professionals including Physicians, APNs, RNs and certified school nurses. It is meant to be useful for anyone with any level of training in dealing with a food allergy reaction.