



WINDER-BARROW COMMUNITY THEATRE

P. O. Box 1720
Winder, GA 30680
www.winderbarrowtheatre.org



**Winder-Barrow Community Theatre and
The Winder Cultural Arts Center Present**

Summer Drama Camp

NAME OF CHILD: _____

NAME OF PARENT: _____

MAILING ADDRESS: _____

PHONE NUMBERS: _____

E-MAIL ADDRESS: _____

Child's age: ___ Grade in school in the fall : _____ (Children age 5 must have completed kindergarten before attending drama camp.)

CIRCLE T-shirt size child size S, M, L, XL **OR Adult size S, M, L, XL (please circle size)**

Check the week of camp you wish to attend:

(1) _____ June 11-15, 2018
_____ **morning session: 9 am to noon, ages: 5 to 9**
_____ **afternoon session: 1 pm to 4 pm, ages: 10 to 14**

(2) _____ June 25-29 2018
_____ **morning session: 9 am to noon, ages: 5 to 9**
_____ **afternoon session: 1 pm to 4 pm, ages: 10 to 14**

Cost for camp is \$35 per child. Applications must be received before June 1st. Students will be accepted on a first come, first serve basis. A waiting list will be compiled if necessary. Each child may attend one week of camp. Call Pam at 770-867-6193 with any questions.

SIGNATURE OF PARENT: _____

DATE SIGNED: _____

MEDICAL WAIVER

STUDENT NAME:

HOME/CELL PHONE:

In the event of an emergency while my son/daughter is attending Drama Camp, I grant permission to the director or any other adult worker to take whatever action necessary to obtain emergency care or treatment if deemed necessary. In the event that I cannot be reached, I hereby authorize the above named to give consent for my child, _____, to receive medical treatment.

Student Address:

City, Zip:

Student date of birth: _____

Mother's Name: _____ **Phone:** _____

Father's Name: _____ **Phone:** _____

Parent e-mail address (please write clearly)

Health Insurance Company

Insured's Name on the card:

Policy/member ID number: _____

Group Name or Number _____

Person(s) to be notified other than parent or guardian in an emergency:
Name/phone

MEDICAL INFORMATION

In the event of an emergency, your child's welfare depends on the explanation of any medical problems. Please be specific. Circle yes or no. Explain YES answers on the next page.

Contacts or glasses	YES	NO	Dental Appliances	YES	NO
Asthma (medication)	YES	NO	Convulsions, seizures	YES	NO
Heart murmur, high blood pressure, heart abnormalities				YES	NO
Diabetes (insulin)	YES	NO	Neck or spine injury	YES	NO
Broken bones	YES	NO	Nervous conditions	YES	NO
Headaches/migraines	YES	NO	Fainting spells	YES	NO
Bone/joint problems	YES	NO	<u>Medicine allergies</u>	YES	NO
<u>Food allergies</u>	YES	NO	Seasonal allergies	YES	NO

Child's name: _____

Since snacks will be provided, we need to know what foods, if any, your child is allergic to. If None, please write None as the answer.

- **My child is allergic to the following foods:**

Does your child have any physical or emotional special needs that we must be aware of in order to insure your child has a positive week? Example: autistic, behavior problems, etc. If so, please explain here.

Primary care physician:

Doctor's phone number:

Preferred hospital:

(Any life threatening illness/injury will be treated at the nearest emergency center)

Parent's signature: _____ **Date:** _____