278 Great Road
Acton, MA 01720
978-302-0985

Summer Camp Registration Form

ATTENDEE INFORMATION (one child per form)			
Last:	First:		MI:
Nickname		Grade in September 2018:	
Birthday (MM/DD/YYYY)			
Please circle: Male or Female			
Allergies			
Special Accommodations			
PARENT/ GUARDIAN INFORMATION			
Name(s)			
Mailing Address			
City, State, Zip			
Home Phone		Cell Phone:	
E-mail Address			
List anyone authorized who may pick up your child including yourself. ID required-- must match designated pick-up			

Which Session will you attend?

Session 1: July 9 - July 20	
Session 2: July 23 - August 3	

Required Paperwork:

- Emergency Contact Form
- Photo Release Form
- Copy of your child's physical and immunization record dated within two calendar years of session week participation. These records must be on file prior to the first day of camp, or child will not be admitted due to Board of Health regulations.

Theatre With a Twist, Inc.

Emergency Contact and Medical Information for a Child

Child's Name

Date of Birth

M F
Gender

Parent's/Guardian's Name

Primary Phone

Secondary Phone

Address

City, ST ZIP Code

Parent's/Guardian's Name

Primary Phone

Secondary Phone

Address

City, ST ZIP Code

Alternative Emergency Contacts

Primary Emergency Contact 1

Primary Phone

Secondary Phone

Address

City, ST ZIP Code

Secondary Emergency Contact 1

Primary Phone

Secondary Phone

Address

City, ST ZIP Code

Medical Information

Hospital/Clinic Preference

Physician's Name

Phone Number

Medication Dispensed at Camp

Epi Pen

Allergies/Special Health Considerations

I authorize all medical and surgical treatment, X-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment. This waiver applies only in the event that neither parent/guardian can be reached in the case of an emergency.

Parent's/Guardian's Signature

Date

I give permission for my child to go on field trips. I release Theatre with a Twist, Inc. and individuals from liability in case of accident during activities related to Theatre with a Twist, Inc., as long as normal safety procedures have been taken.

Parent's/Guardian's Signature

Date

Updated: 6/1/16

Photograph Release

Theatre with a Twist, Inc.
PO Box 593
Acton, MA, 01720

Event: _____

I grant to Theatre with a Twist, Inc. the right to take photographs of me/ my child in connection with the above-identified event. I authorize Theatre with a Twist, Inc., its assigns and transferees to copyright, use and publish the same in print and/or electronically.

I agree that Theatre with a Twist, Inc. may use such photographs of me/ my children with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content.

I have read and understand the above:

Participant Name

_____

Parent/Guardian Name (please print) (as applicable)

_____

Parent/Guardian Signature (as applicable)

_____

Date

_____

Authorization To Dispense Medication At Camp

If medication can be given at home or after camp hours, please do so. However, if medication must be given during camp hours, this form must be completed. Please write one medication per page.

Student's Name: _____

I request that Theatre with a Twist, through the camp director or RN assist in the administering of medication to my child, according to the instructions below.

I understand that:

• Medications must be in the original labeled container (no baggies, foil, etc.). Pharmacists can provide a duplicate labeled container with only the school doses.

• Parent/guardian must provide specific instructions, as well as the medication

and any related equipment to the camp director.

• It will be the responsibility of the parent/guardian to inform the camp of any changes.

New medication or new doses will not be given unless a new form is completed and a

newly labeled container is provided.

• All medication will be taken directly to the camp director by the parent.

• Unused medication will be disposed of unless picked up within one week after medication is discontinued.

*** By signing this form I am acknowledging that the first dose of this medication was given by a parent or guardian and student was observed to have no known side effects

****

Name of Medication: _____

Dose: _____ Route (by mouth, topical, etc): _____

Time(s) to be given: _____ Stop Medication on: _____

Condition/Illness Requiring Medication: _____

Possible Side Effects, if any: _____

Physician's Name: _____ Physician's Phone: _____

I hereby authorize the personnel, employees and officials of Theatre with a Twist to assist my child in taking prescribed medication according to district policy and I release them from any liability for administering this medication. I understand that, in the event of a change in medicine, I am responsible for presenting a new request form.

_____

Parent/ Legal Guardian signature Date

Home Phone_____ Work Phone_____

Pager/Cell Phone _____

To be completed by School Health Clinic Personnel only:

Date received: _____ Name of Medication: _____

Doses: _____