



## ACT Project Participant Registration

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NAME DOB AGE

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ADDRESS

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PARENT/GUARDIAN

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ADDRESS (IF DIFFERENT FROM ABOVE)

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HOME PHONE CELL PHONE WORK PHONE E-MAIL

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PARENT/GUARDIAN

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ADDRESS (IF DIFFERENT FROM ABOVE)

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HOME PHONE CELL PHONE WORK PHONE E-MAIL

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EMERGENCY CONTACT RELATIONSHIP WORK/HOME PHONE CELL

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DOCTORS NAME PHONE HOSPITAL PREFERENCE

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DIAGNOSIS CURRENT MEDICATIONS

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PHYSICAL LIMITATIONS

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ALLERGIES / ANY OTHER PHYSICAL CONDITIONS / ISSUES WE NEED TO BE AWARE OF

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SCHOOL ADDRESS / PHONE GRADE/PROGRAM

I hereby give permission for my son / daughter \_\_\_\_\_ to participate in The ACT Project. I understand that as a family we are making a commitment to attend weekly workshops / rehearsals from \_\_\_\_\_ through \_\_\_\_\_ and we agree to make every effort to attend all workshops, rehearsals and performances. The participant (parent/guardian) waives all and any claims against The ACT Project, its staff, volunteers, landlords or lessors for any injuries, illness or loss to myself or my child by any reason of participation in workshops, classes, performances, or other activities held by or in conjunction with The ACT Project. In addition, the undersigned acknowledges that in consideration of the participant being permitted to participate in any ACT Project program, agree that the participant has no medical conditions that would disallow participation and therefore will be responsible for and hereby release and agree to hold The ACT Project harmless from any and all liability by reason of injury to the participant, themselves, their property, or dispute that might arise during any ACT Project activity or function. I understand that my child may be involved in physical activities while involved in this program and I agree that I have disclosed any condition / issue that may impact my child's participation in the program.

I accept the conditions listed above.

\_\_\_\_\_  
Parent/Guardian Signature / Date

I give permission for my child to be photographed and/or videotaped for instructional and internal purposes.

\_\_\_\_\_  
Parent/Guardian Signature / Date

I give permission for photographs and videotapes of my child to be used in program-related publications, newspaper, magazine, or other printed or electronic media for training, educational, community awareness, or informational purposes.

\_\_\_\_\_  
Parent/Guardian Signature / Date

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Strengths:

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Talents / Interests:

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Greatest social challenges:

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Goals you'd like to see your child accomplish via this program:

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Issues, triggers, fears, passions, etc. that we should be aware of:

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Effective calming strategies:

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Services provided in or out of school:

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Special supports that might be needed for your child to be successful in this program:

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On the back or on a separate sheet please let us know anything else that you think might be important for us to know about your child.

Thank you!!