



## Summer 2018 REGISTRATION

*Please complete this application and mail in with tuition fees to:  
The Cue Theatre, Inc.; PO BOX 526, Slingerlands, NY 12159*

Student's Name \_\_\_\_\_  
Mailing address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Student Email \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age as of 6/2017 \_\_\_\_\_ Gender: (circle) M F

Please provide any medical or non-medical information about your child that we should know:

\_\_\_\_\_  
\_\_\_\_\_

### PARENT INFORMATION

Parent 1/Guardian Name \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Email \_\_\_\_\_  
Parent 2/Guardian Name \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Email \_\_\_\_\_  
Student Resides with:  Both Parents  Mother  Father  Other \_\_\_\_\_

### PARENT SIGNATURE/WAIVER

To the best of my knowledge, the information on these forms is correct. I hereby give permission to the person herein described to engage in all prescribed Cue Theatre activities, on or off property, except as noted. In consideration of the use of space occupied by The Cue Theatre, I (parent/gardian) am assuming full risk of injury arising from the use of these facilities. Any personal belongings that my child/ward brings with him/her to Cue Theatre is at his/her own risk and is not the responsibility of the Cue Theatre. Further, Cue Theatre's insurance does NOT cover these items. I understand that while at Cue Theatre programs pictures and/or video may be taken and used for publicity purposes. The Cue Theatre will not release or publish the names of any student, with the exception of information related specifically to performances. I understand that while at The Cue Theatre, my child will be expected to behave following the guidelines set by Cue's director and staff.

In Case of Emergency, I understand every effort will be made to contact me. In the event that I cannot be reached, I hereby give my permission to Cue Theatre staff to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child. Permission is given to transport my child for medical assistance. This form may be photocopied for use at camp. I understand that I am responsible for payment of all medical treatments received. If my child needs medical treatment, I hereby authorize any doctor or hospital treating the student while he is at Cue to discuss and release information regarding such treatment or follow-up care to an authorized representative of The Cue Theatre. I understand that this authorization will remain in effect while the student is engaged in 2018/19 programming and will expire no later than August 31, 2019.

\_\_\_\_\_  
Signature and Date of Parent/Guardian

# REGISTRATION AND PAYMENT

Student Name: \_\_\_\_\_

For Information on confidential Financial Assistance, email us at [TheCueTheatre@gmail.com](mailto:TheCueTheatre@gmail.com).  
Forms can be downloaded from [www.TheCueTheatre.org](http://www.TheCueTheatre.org)

- Please fill out a separate registration, payment and medical form for each child that you are registering for The Cue Theatre.
- Sibling Discounts of 10% are applied to the application fees for the second, third, etc. child registered for programs.
- First United Methodist Church members receive a 15% discount for tuition.

Program Name	EARLY BIRD (by May 15)	Tuition	Amount Due
Summer Intensive: School of Rock (Aug 20 – Sept 1)	\$430	\$460	
		SUBTOTAL	
			<i>Less 10% Sibling Discount (for second, third, etc)</i>
			<i>Less 15% Discount for FUMC members</i>
		GRAND TOTAL	
		T-SHIRT SIZE	

**PAYMENT METHOD:**

\_\_\_\_\_ Check/Cash/Money Order *made payable to The Cue Theatre, Inc.*  
 \_\_\_\_\_ Credit Card; Provide email address (link to online payment will be sent) \_\_\_\_\_

**\*Refund Policy:** The Cue Theatre's programs and productions are tuition-based programs. Tuition and Annual Registration Fees are non-refundable. No cash refunds will be issued, except in the case of program cancellation. Full and partial credits toward future programs will be issued at the discretion of Cue administration. All tuition credits will be honored up to one year after the initial program start date. **For classes and camps:** Requests made in writing up to one week prior to program start date will receive a credit applied to Cue programs for the full amount originally paid, less \$20 annual registration fee. Requests made less than one week prior to program start date will receive a 75% credit for the amount paid. Requests made after a program start date will receive a pro-rated credit of up to 60% of program value toward future tuition. **For productions:** Cast selection is a key piece in creating a show and decisions are made very carefully and thoughtfully. Once a role has been accepted, tuition is due in full at the first read-through (unless prior arrangements have been made). Production tuition is non-refundable. Credit toward future programs will only be issued at the discretion of Cue administration.

# Cue Theatre 2018 Medical Form

(Due before first day of attendance)

Student Name \_\_\_\_\_

**Instructions:** This two-page form is required for all students attending Cue Theatre during the 2018 season. This medical record is a complete health history that requires a physician's signature indicating that the student is fit to attend Cue programs. Students without a completed medical form will not be allowed to participate and will be sent home.

## PERSONAL INFORMATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Parent or Guardian: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

## EMERGENCY CONTACT INFORMATION (OTHER THAN PARENTS)

Name #1 \_\_\_\_\_

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Relationship to student \_\_\_\_\_

Name #2 \_\_\_\_\_

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Relationship to student \_\_\_\_\_

## INSURANCE

Personal health/accident insurance provider: \_\_\_\_\_

Policy Number: \_\_\_\_\_

## HEALTH HISTORY/INFORMATION

Primary Physician/Phone Number: \_\_\_\_\_

Dentist/Phone Number: \_\_\_\_\_

Has or is subject to:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Bee Stings                               | <input type="checkbox"/> Convulsions     |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> High BP                                  | <input type="checkbox"/> Heart Trouble   |
| <input type="checkbox"/> Sports Restrictions | <input type="checkbox"/> Kidney Disease                           | <input type="checkbox"/> Cancer/Leukemia |
| <input type="checkbox"/> Hemophilia          | <input type="checkbox"/> Attention-Deficit Hyperactivity Disorder |  |

Restrictions or Allergies: \_\_\_\_\_

Has Difficulty With:  Eyes, Ears, Nose, Throat  Digestion  Lungs  Other

Takes Medication:  No  Yes, Name of Medication(s): \_\_\_\_\_

*Over the Counter Medication taken during camp must be accompanied by a physician's signature and written instruction from the physician.*

## Limitations:

Diet Restrictions \_\_\_\_\_

Activity Restrictions: \_\_\_\_\_

**HEALTH EXAMINATION** (To be completed by a licensed medical practitioner):

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_\_  
Pulse: \_\_\_\_\_

Check box if abnormal:

- |   |   |
|---|---|
| <input type="checkbox"/> Growth Development | <input type="checkbox"/> Cardiopulmonary System   |
| <input type="checkbox"/> HEENT              | <input type="checkbox"/> Teeth                    |
| <input type="checkbox"/> Skin               | <input type="checkbox"/> Neurobehavioral          |
| <input type="checkbox"/> Hernia             | <input type="checkbox"/> Genitalia                |
| <input type="checkbox"/> Musculoskeletal    | <input type="checkbox"/> Eyes, Ears, Nose, Throat |
| <input type="checkbox"/> Other              |   |

Details \_\_\_\_\_

\_\_\_\_\_

**Immunizations:**

(Indicate Original Date and also most recent Month/Year for Date of Last Inoculation. Cannot say "up to date.")

Tetanus \_\_\_\_\_

Mumps \_\_\_\_\_

Diphtheria \_\_\_\_\_

Rubella \_\_\_\_\_

\*Haemophilus Influenza Type B \_\_\_\_\_

Pertussis \_\_\_\_\_

Polio \_\_\_\_\_

Measles \_\_\_\_\_

Chicken Pox \_\_\_\_\_

\*Hepatitis B \_\_\_\_\_

\*N/A If Not Given

Signature: \_\_\_\_\_ MD/DO/PA/RNP

Date: \_\_\_\_\_