

St. Luke's Presbyterian Church and Missoula Children's Theatre
Summer Camp 2010 ~ July 26th through July 31st



REGISTRATION FORM

St. Luke's Presbyterian Church - 1978 Mt Vernon Rd - Dunwoody, GA 30038

Main: 770-393-1424 & Fax: 770-393-3278

Please return form & check (made payable to St. Luke's Presbyterian Church) to Liz Catlett

Name _____ Male _____ Female _____

Address _____

Home Phone _____ Email _____

Please circle correct T-shirt size: YS YM YL ADS ADM ADL

Age _____ Date of Birth _____ Grade Entering in the fall _____

Parent(s) Name _____ Cell# _____

Emergency Contact _____ Phone _____

Fee: \$175 which includes t-shirt and a healthy snack (Financial assistance is available.)

Note: Please make checks payable to St. Luke's Presbyterian Church and put "Theatre Arts Camp" on memo line. The \$175 includes a non-refundable registration fee of \$30.

PARENT MUST PROVIDE SACK LUNCH EACH DAY OF CAMP

ATTENDANCE: The week culminates in a full theatre production in which all children will have a part. It is imperative that participants attend camp every day for rehearsal & that they are present on Saturday, July 31st for rehearsal and the performance. By registering for camp, you understand this policy and agree to abide by it, except in the case of illness. Please contact Glenda Gray (770-880-8593), camp coordinator, with questions *prior* to registering. Family Discount of \$10 per child.

WAIVER OF LIABILITY AND RELEASE: In consideration of the services provided, St. Luke's Presbyterian Church and its agents will abide by all reasonable standards and due diligence. I hereby release and hold harmless St. Luke's Presbyterian Church and their officers, directors, employees, and agents from any and all liability for injuries including those resulting in illnesses and death incurred while participating or attending any event or in any facility of St. Luke's Presbyterian Church. By signing this document, the participant or legal guardian confirms that he or she has authority to sign, has read the entire document, and has understanding that the document waives certain rights of the person signing or the participant.

(Please Print)

Participant Name _____

Parent/Guardian Name _____

Parent/Guardian Signature _____ Date _____

Please complete "Authorization to Treat Minor" on back.

AUTHORIZATION TO TREAT A MINOR

I/We, the undersigned parents(s) or legal guardian of _____, a minor, do hereby consent to an X-ray examination, anesthetic, medical or surgical diagnosis, treatment or procedures and hospital care which is deemed advisable by, or is suggested, recommended, prescribed or directed by, any physician or surgeon duly licensed to practice in the State of Georgia.

It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatments will not be withheld if the undersigned cannot be reached.

This authorization shall remain in effect until July 31, 2010.

Child's Name _____

Date of Birth _____

Address _____

Home # _____ Grade Completed as of 6/1/10 _____

Allergies to Drugs or Food

Does Your Child Carry an Epi-Pen? Yes _____ No _____

Any Special Medications or Pertinent Information

Family Physician _____ Phone # _____

Parent or Legal Guardian _____

Address _____

Telephones where parents may be reached:

Father's Name _____ H # _____ W#/C# _____

Mother's Name _____ H # _____ W#/C# _____

AUTHORIZATION (Please Sign)

Father _____ Date _____

Mother _____ Date _____

Witness _____ Date _____

_____ No, I do not wish to sign the authorization