Toledo Repertoire Theatre Rep Education Program

Registration and Emergency Medical Authorization Form

No cash refunds will be made after the second week of class. Refunds after this date will be pro-rated (at $12.00 per remaining session) in the form of a credit toward a future Rep Ed class.

STUDENT:_____ AGE:_____

ADDRESS:_____ DATE OF BIRTH:_____

_____

HOME PHONE:_____ T-SHIRT SIZE _____

MOTHER CONTACT INFORMATION

NAME:_____

DAY PHONE:_____

CELL PHONE:_____

EMAIL:_____

FATHER CONTACT INFORMATION

NAME:_____

DAY PHONE:_____

CELL PHONE:_____

EMAIL:_____

EMERGENCY CONTACT

CALL 1ST:_____

RELATIONSHIP:_____

PHONE:_____

CALL 2ND:_____

RELATIONSHIP:_____

PHONE:_____

Please indicate custodial parent:

_____ Mother & Father _____Mother _____Father _____Guardian

Please list anyone who is **NOT PERMITTED** to visit or pick up your child from class.

Name:_____

Name:_____

COMPLETE EITHER PART 1 OR PART 2 BUT NOT BOTH

STUDENT NAME:_____

PART 1: I grant consent for treatment medical care providers and local hospital (PLEASE PROVIDE NAME AND PHONE NUMBER).

PHYSICIAN:_____DENTIST:_____

PHONE:_____ PHONE:_____

PREFERRED HOSPITAL:_____

CHILD HEALTH CONDITIONS:_____

_____

LIST ALL MEDICATIONS YOUR CHILD TAKES:

LIST ALL ALLERGIES YOUR CHILD HAS:_____

IN THE EVENT WE ARE UNABLE TO CONTACT IN A PARENT IN AN EMERGENCY, THE TOLEDO REPERTOIRE THEATRE WILL HAVE YOUR CHILD TRANSPORTED BY LOCAL EMS TO THE NEAREST HOSPITAL.

_____

Parent/Guardian Signature

I give my permission for_____'s health information to be shared with Rep staff and emergency care personnel as needed.

_____YES _____NO

_____ _____

Parent/ Guardian Signature Date

PART 2: REFUSAL TO GIVE CONSENT FOR TREATMENT TO MEDICAL CARE PROVIDERS AND LOCAL HOSPITAL

I DO NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring medical treatment, I wish the Toledo Repertoire Theatre Education staff to take ONLY the following action:

_____

_____

_____

_____

Parent/Guardian Signature