

THE REBEL SHAKESPEARE COMPANY

Participation and Authorization Waiver

In consideration of the benefits to be derived through participation in the Rebel Shakespeare Company summer workshops, and having full confidence that every precaution will be taken to ensure the safety and well-being of my child/ward during his or her involvement with the Rebel Shakespeare Company, I hereby agree to his or her participation and waive all claims against the instructors, artists, officers and representatives of the Rebel Shakespeare Company.

I understand that my child/ward should apply sunscreen before arriving in the morning. I hereby grant permission to apply sunscreen to my child/ward if needed.

On drop-off and pick-up, students should enter and exit vehicles safely and remain on the sidewalk/at the side of the road. Make sure a director is present *before* you drop off your child. Parents/guardians should make a reasonable effort to park at the side of the road and not obstruct normal traffic.

Parent/Guardian SIGNATURE: _____ **Date:** _____

NAME OF STUDENT: _____ **Age:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Emergency and Health Information

To be completed by parent or guardian only – PLEASE PRINT LEGIBLY

Name of Parent/Guardian _____

Home Phone: (_____) _____ **Work Phone:** (_____) _____

Two additional emergency contacts (other than parent/guardian listed above)

1) **Name:** _____ **Phone:** (_____) _____ **Relationship:** _____

2) **Name:** _____ **Phone:** (_____) _____ **Relationship:** _____

Family Physician/Pediatrician: _____ **Phone:** (_____) _____

Health Insurance Company: _____ **Policy Number:** _____

Does your child/ward suffer from any of the following: Asthma, diabetes, seizure disorders, heart trouble, bleeding disorders, fainting spells, or allergies to medications, foods, plants or insects? _____

If Yes, please detail here: _____
(continue on reverse side if needed)

Does your child require regular medication? _____ **Name of Medication:** _____

If Yes, please request "Authorization to Administer Medication" form and return before program begins.

Has your child/ward been diagnosed with any type of learning disability? If yes, please explain: _____

(continue on reverse side if needed)

Parent/Guardian Authorization: *In the event that I cannot be reached in an emergency, I hereby grant permission to an emergency room physician to secure proper treatment for my child/ward.*

Parent/Guardian SIGNATURE: _____ **Date:** _____

PLEASE ATTACH A COPY OF YOUR CHILD/WARD'S IMMUNIZATION RECORD.

By state law, without proper immunization records your child/ward may not attend the program.