WINDER-BARROW COMMUNITY THEATRE
P. O. Box 1720
Winder, GA 30680
www.winderbarrowtheatre.org

Winder-Barrow Community Theatre
Presents

Summer Drama Camp

NAME OF CHILD: _____

NAME OF PARENT: _____

MAILING ADDRESS: _____

_____

PHONE NUMBERS: _____

E-MAIL ADDRESS: _____

Child's age on June 1st: _____ Grade in school in August: _____(Children must have completed kindergarten before attending drama camp.)

CIRCLE T-shirt size child size S, M, L, XL OR Adult size S, M, L, XL (please circle size)

Check the week of camp you wish to attend:

(1)_____ June 17- 21, 2024
_____morning session: 9 am to noon, ages: 6 - 10
_____afternoon session: 1 pm to 4 pm, ages: 11 to 15

(2)_____ July 15-19, 2024
_____morning session: 9 am to noon, ages: 6 to 10
_____afternoon session: 1 pm to 4 pm, ages: 11 to 15

Cost for camp is $60 per child. Applications must be received before June 1st for the first week and July 1st for the second week. Students will be accepted on a first come, first serve basis. A waiting list will be compiled if necessary. Any questions should be sent to ask@winderbarrowtheatre.org.

SIGNATURE OF PARENT: _____
DATE SIGNED: _____

MEDICAL WAIVER

STUDENT NAME:

_____

HOME/CELL PHONE:

_____

In the event of an emergency while my son/daughter is attending Drama Camp, I grant permission to the director or any other adult worker to take whatever action necessary to obtain emergency care or treatment if deemed necessary. In the event that I cannot be reached, I hereby authorize the above named to give consent for my child, _____, to receive medical treatment.

Student Address:

_____

City, Zip:

_____

Student date of birth: _____
Mother's Name: _____Phone: _____
Father's Name: _____ _____Phone: _____
Parent e-mail address (please write clearly)

_____

Health Insurance Company

_____

Insured's Name on the card:

_____

Policy/member ID number: _____
Group Name or Number_____
Person(s) to be notified other than parent or guardian in an emergency:
Name/phone

_____

MEDICAL INFORMATION

In the event of an emergency, your child's welfare depends on the explanation of any medical problems. Please be specific. Circle yes or no. Explain YES answers on the next page.

Contacts or glasses	**YES**	**NO**	**Dental Appliances**	**YES**	**NO**
Asthma (medication)	**YES**	**NO**	**Convulsions, seizures**	**YES**	**NO**
Heart murmur, high blood pressure, heart abnormalities				**YES**	**NO**
Diabetes (insulin)	**YES**	**NO**	**Neck or spine injury**	**YES**	**NO**
Broken bones	**YES**	**NO**	**Nervous conditions**	**YES**	**NO**
Headaches/migraines	**YES**	**NO**	**Fainting spells**	**YES**	**NO**
Bone/joint problems	**YES**	**NO**	**Medicine allergies**	**YES**	**NO**
Food allergies	**YES**	**NO**	**Seasonal allergies**	**YES**	**NO**

Child's name: _____

Since snacks will be provided, we need to know what foods, if any, your child is allergic to. If None, please write None as the answer.

- **My child is allergic to the following foods:**
  _____
  _____
  _____
  _____
  _____

Does your child have any physical or emotional special needs that we must be aware of in order to insure your child has a positive week? Example: autistic, behavior problems, etc. If so, please explain here.

_____
_____
_____
_____
_____

Primary care physician:
_____
Doctor's phone number:
_____
Preferred hospital:
_____
(Any life threatening illness/injury will be treated at the nearest emergency center)

Parent's signature: _____Date: _____