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 age 5 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 5-9, 2023
______morning session: 9 am to noon, ages: 5 to 9
______afternoon session: 1 pm to 4 pm, ages: 10 to 15

(2)_____ July 17-21, 2023
______morning session: 9 am to noon, ages: 5 to 9
______afternoon session: 1 pm to 4 pm, ages: 10 to 15

Cost for camp is $50 per child. Applications must be received before June 1st for the first week and July 10th 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: _______________________________________

The Winder-Barrow Community Theatre is a 501(c)3 Corporation and a proud member of the Barrow County Chamber of Commerce.

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: ____________