

ATLA THEATRE CHILDREN'S WORKSHOP
ENROLLMENT INFORMATION 2019

(REFUNDS ARE REDUCED BY 25% BEFORE OPENING DAY & 50% AFTER)

Student Name: _____ DOB: _____ Age: _____

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

Primary Parent/ Guardian: _____ Cell Phone: _____ Work _____

2nd Parent/ Guardian: _____ Cell Phone: _____ Work _____

Home Phone: _____ Preferred Phone (check one): Cell _____ Work _____ Home _____

Parent/Guardian's E-mail address: _____

MEDICAL RELEASE FORM

Emergency Information must be provided for your child to attend workshops.

Mother: _____ Home Phone: _____ Cell #: _____ Work#: _____

Father: _____ Home Phone: _____ Cell #: _____ Work#: _____

Emergency Contact: _____ Home#: _____ Cell#: _____

Insurance/Medical Plan: _____ Policy # _____ (Optional)

Doctor _____ Phone#: _____

Please circle the following if they apply to your child, please be specific:

1. Allergies: (What Kind?) _____
2. Mental /Emotional Disorders: _____
4. Learning Disorders: _____
5. Hyperactive: _____
6. Other medical conditions: _____
7. None _____

Please indicate all medications currently prescribed to your child: _____

I have read and understand the ATLA Theatre Company enrollment information. I hereby give ATLA Theatre personnel permission to see that my child receives medical treatment in the event of an emergency. I am financially responsible for all charges incurred in the rendering of emergency treatment, regardless of my medical insurance coverage. By signing below I agree that I am the legal guardian of participant and agree to the terms contained herein on behalf of participant:

Sign: _____ DATE: _____
PARENT/GUARDIAN

*****For Office Use Only – Do Not Write Below*****

Tuition Amount: **\$60.00/child** Resident: Yes No Date Paid: _____

Amount Paid: _____ Receipt No. _____