

WINDER-BARROW COMMUNITY THEATRE

P. O. Box 1720

Winder, GA 30680

[www.winderbarrowtheatre.org](http://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 7-11, 2021  
\_\_\_\_\_ morning session: 9 am to noon, ages: 5 to 9  
\_\_\_\_\_ afternoon session: 1 pm to 4 pm, ages: 10 to 14

(2) \_\_\_\_\_ June 21-25, 2021  
\_\_\_\_\_ morning session: 9 am to noon, ages: 5 to 9  
\_\_\_\_\_ afternoon session: 1 pm to 4 pm, ages: 10 to 14

**Cost for camp is \$45 per child.** Applications must be received before June 1st. Students will be accepted on a first come, first serve basis. A waiting list will be compiled if necessary. Each child may attend one week of camp. Call Pam at 770-867-6193 with any questions.

SIGNATURE OF PARENT: \_\_\_\_\_

DATE SIGNED: \_\_\_\_\_

## MEDICAL WAIVER

**STUDENT NAME:**

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**HOME/CELL PHONE:**

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**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:**

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**City, Zip:**

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**Student date of birth:** \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Father's Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Parent e-mail address (please write clearly)**

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**Health Insurance Company**

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**Insured's Name on the card:**

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**Policy/member ID number:** \_\_\_\_\_

**Group Name or Number** \_\_\_\_\_

**Person(s) to be notified other than parent or guardian in an emergency:**  
**Name/phone**

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### 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.**

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

**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:** \_\_\_\_\_