2008 Drama Camp
Registration Form
Camp Date: Saturday, May 17th, 2008

Student Name ________________________________

Grade ______ Age ______ Gender ______________

School _______________________________________

Homeroom Teacher ___________________________

Parent Name _________________________________

Address _____________________________________

City/Zip _____________________________________

Telephone ___________________________________

Registration is $20, which includes all workshops, lunch, and a mini performance by campers at 3:00 pm. Camp will begin at 9am, and students should be picked up at 3:30 pm. Parents are encouraged to arrive early to attend the performance. Please note that the camp will be held at the Middle School.

Checks should be made payable to:
LHS Drama Club
Mail registration and medical form with payment to:
Logan High School
Attn: Shelly Riggs
50 North Street
Logan, OH 43138

Registration Deadline is Friday, May 9th.

EMERGENCY MEDICAL AUTHORIZATION

Purpose: To enable to authorize emergency treatment for children who become ill or injured at Drama Camp when parents cannot be reached. PART I or PART II must be completed.

PART I: CONSENT

Student's Name ______________________________________School______________________________
Address______________________________________Phone(___)___________________________
City____,OH Zip___________________________________

Residential Parent or Guardian
Mother______________________________________Daytime Phone(_________)_____________________
Father______________________________________Daytime Phone(_________)_____________________
Other authorized contact_______________________________Phone(_________)_____________________
Name of relative or childcare provider____
Address_______________________Phone(_________)_____________Relationship___________________

In the event reasonable attempts to contact me or those listed above are unsuccessful, I hereby give consent for the following medical care providers and local hospital to be called. I further authorize the administration of any treatment deemed necessary by the preferred doctors, or in the event the preferred practitioner is not available, by another licensed physician or dentist, and the transfer of the child to the preferred hospital or any hospital reasonably accessible.

Doctor_______________________________________Phone (________)___________________________
Dentist______________________________________Phone (________)___________________________
Medical Specialist_____________________________Phone (________)___________________________
Local Hospital_________________________________Phone (________)___________________________

This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before the surgery is performed.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physicians should be alerted:____
____

Signature of Parent/Guardian___________________________________Date__________________________

PART II: REFUSAL OF CONSENT (Do not complete Part II if you completed Part I)

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school to take no action or to take the following action:________
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Signature of Parent/Guardian___________________________________Date__________________________
Address____