



www.VOICETheatre.org

219 Avenue B, # 3B, NYC 10009

P.O. Box 353, Bearsville, NY, 12409

Studio: 917 494 6273 Box Office: 845 679 0154

MEDICAL WAIVER FORM

PLEASE PRINT AND COMPLETE THIS FORM, SEND TO:

Voice Theatre, VT, PO BOX 353, BEARSVILLE, NY, 12409

This form MUST be received by June 27TH prior to the start of camp.

Your child or children will NOT be able to attend if forms are not received by this date.

CHILD'S INFORMATION: If you have multiple children attending, a separate form MUST be completed for each

FIRST NAME _____

LAST NAME _____

AGE _____

BOY OR GIRL _____

PRIMARY CONTACT'S INFORMATION:

FIRST NAME _____

LAST NAME _____

PHONE NUMBER _____

ADDRESS CITY STATE ZIP _____

IF I'M NOT AVAILABLE IN AN EMERGENCY, PLEASE NOTIFY:

(Include 2 contacts and list in order of preference)

1. NAME _____

2. PRIMARY PHONE _____

3. SECONDARY PHONE _____

4. RELATIONSHIP TO CHILD _____

2.

1. NAME _____

2. PRIMARY PHONE _____

3. SECONDARY PHONE _____

4. RELATIONSHIP TO CHILD _____

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ATTENTION: YOU MUST NOTIFY VT IF YOUR CHILD IS EXPOSED TO A COMMUNICABLE DISEASE

WITHIN THREE WEEKS OF ATTENDING CAMP AND/OR WHILE ATTENDING CAMP

Please call VT if your child has a disability and/or diagnosed behavioral disorder so that we can ensure that your child has an enriching and enjoyable experience while in attendance

PLEASE ANSWER THE FOLLOWING QUESTIONS: You can attach additional pages, if necessary

IS YOUR CHILD RESTRICTED FROM PERFORMING ANY SPECIFIC ACTIVITIES?

DOES YOUR CHILD HAVE ANY DIETARY RESTRICTIONS OR ALLERGIES?

IS YOUR CHILD CURRENTLY BEING TREATED BY A PHYSICIAN? IS HE/SHE TAKING MEDICATION? PLEASE EXPLAIN.

I hereby authorize that the information I have provided is truthful and complete and that my child, as herein described, has permission to engage in all camp activities, except those noted by me on this form. In the event that I cannot be reached during an emergency, I hereby give VT permission to call emergency medical personnel to secure proper treatment, order injection, anesthesia or surgery and/or hospitalization for my child as named above.

I understand that VT cannot administer ANY medications to my child, including epi-pen injections and inhalers. If my child is authorized to administer this him/herself, I can send the medication to camp to be carried by my child. Furthermore, if I have not authorized my child to administer medications, I take full responsibility for administering his/her medication. I understand that VT and any/all of its associates will NOT carry or store any of my child's medication. In the case that I am responsible to administer my child's medication I will carry it on and off-site.

PRINT NAME

SIGNATURE

DATE
