www.voicetheatre.org
P.O. Box 353, Bearsville, NY, 12409
Cell: 917 494 6273 Box Office: 845 679 0154

# MEDICAL WAIVER FORM

**ATTENTION: YOU MUST NOTIFY VT IF YOUR CHILD IS EXPOSED TO A COMMUNICABLE DISEASE SUCH AS COVID IMMIDIATELY.**

**PLEASE PRINT AND COMPLETE THIS FORM, SEND TO:**
**Voice Theatre, VT, PO BOX 353, BEARSVILLE, NY, 12409 or info@voicetheatre.org**
**This form MUST be received prior to the start of the workshop.**
**Your child or children will NOT be able to attend if this form is not received prior to the workshop.**
**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 OR Non-Binary_____
PRONOUNS_____

**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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**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

**HAS YOUR CHILD BEEN VACCINATED AGAINST COVID? _____ DATE (S):_____**

IS YOUR CHILD RESTRICTED FROM PERFORMING ANY SPECIFIC ACTIVITIES?

_____

_____

DOES YOUR CHILD HAVE ANY DIETARY *OR* SPECIAL NEEDS 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

_____