

ImPACT



Imagine Performing Arts Camp & Theatre

Registration Form

Camper's Name: _____ Age: _____ Grade: _____

School Name: _____

Home Address: _____ City: _____ Zip: _____ Phone: _____

Email Contact: _____

Parent/Guardian: _____ Phone: _____

Deposit and Refund Policy:

A registration fee of \$25.00 plus the first 2 weeks of tuition (\$400.00) must be paid at the time of registration or before July 10th. If, for any reason, a camper withdraws from camp early, an additional \$100 cancellation fee will be charged, and you are only entitled to 30% refund of any tuition monies paid. Those who withdraw after July 19th will not be entitled to a refund of any tuition paid. The remaining balance of \$600 must be paid by August 1st. Unpaid balances may jeopardize your child's attendance at camp. A late fee of \$10/day will be assessed on any outstanding balance for each day over due.

Waiver and release of Liability:

I hereby agree to indemnify and hold harmless, **CSJ Associates in Production LLC**, the parent company of **ImPACT**, its employees, instructors, and volunteer's from and against any and all liabilities which may be suffered by me or by my child arising out of or connected with participation in the camp attended. In the case of an emergency, I hereby grant permission for my child to be treated by a qualified physician.

I give permission for my child's photo and likeness to be used in all forms of **ImPACT's** publicity brochures and website.

I have read and understand the above:

Print Name: _____

Signature of Parent/Guardian: _____

Date: ___/___/___

Enclosed Check #: _____ Amount: _____

CSJ Associates in Production LLC - 215 791 0357 - 30 Hill Ave Morrisville PA 19067

www.csjproductions.com

csj.nolan@gmail.com

Im.P.A.C.T Medical Release Form

Parent/Legal Guardian's Name: _____

Address: _____

Phone #s: Home (_____) _____ - _____

Work (_____) _____ - _____

Cell (_____) _____ - _____

Other (_____) _____ - _____

In an emergency, please contact: _____

Relationship to child/children: _____

Phone #s: Home(_____) _____ - _____

Work (_____) _____ - _____

Cell (_____) _____ - _____

Other (_____) _____ - _____

Or contact: _____

Relationship to child/children: _____

Phone #s: Home (_____) _____ - _____

Work (_____) _____ - _____

Cell (_____) _____ - _____

Other (_____) _____ - _____

Physician's Name: _____

Address: _____

Phone: (_____) _____ - _____

Dentist's Name: _____

Address: _____

Phone: (_____) _____ - _____

Primary Insurance Company: _____

Phone : (_____) _____ - _____

Billing Address: _____

Policy Holder's Name: _____

Address: _____

Relationship to child/children: _____

ID #: _____ Group/Policy #: _____

Secondary Insurance Company: _____
Phone #: (_____) _____ - _____
Billing Address: _____
Policy Holder's Name: _____
Address: _____
Relationship to child/children: _____
ID #: _____ Group/Policy #: _____

Please list all the medications that have been prescribed by a physician for your child.

Please list any medical problems of which you feel that we need to be made aware of including allergies. All information provided will be kept confidential.

Please list all "over the counter" medications that you have sent with your child. Include information as to when and how much medicine should be taken.

Please list any medications to which your child might have an allergic reaction:

Statement of Consent: *(To be signed in the presence of a legalized notary public.)*

In the event of an emergency or non-emergency situation requiring medical treatment, I, _____, hereby grant permission for any and all medical and/or dental attention to be administered to my child/children, in the event of an accidental injury or illness, until such time as I can be contacted. This permission includes, but is not limited to, the administration of first aid, the use of an ambulance, and the administration of anesthesia and/or surgery, under the recommendation of qualified medical personnel.

Signature: _____ Date: _____

Notarization:

On this _____ day of _____, _____, _____
(date) (month) (year) (name of parent)

personally appeared before me in _____ County (in the state of _____)

and, in my presence, signed this medical release form.

Name of Notary Official: _____

Signature: _____

Commission Expires: _____

Seal: