



ROUND HOUSE THEATRE SPRING BREAK 2012 REGISTRATION FORM

Office Use Only
Rec'd _____
RE _____
PD _____

PARTICIPANT INFORMATION

Participant's Name: _____ Gender: M F
(FIRST) (LAST)
Date of Birth: ____/____/____ School: _____ Grade: _____

PARENT/GUARDIAN INFORMATION *Please provide the information below for the parent/guardian that the participant resides with.*

Parent/Guardian Name: _____ Relationship: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Email: _____

PROGRAM REGISTRATION *Please check the program you would like to register the participant for.*

Grades K – 3: Spring Destinations **Grades 4 – 6: Theatre Adventures**

FULL BREAK: \$300 = \$ _____
DROP- IN: \$75 x _____ = \$ _____

Please circle attending days: M(Apr 2) T(Apr 3) W(Apr 4) Th(Apr 5) F(Apr 6) M(Apr 9)

EZ CARE REGISTRATION

(per day) **BEFORE CARE** \$10 x _____ = \$ _____

Please circle attending days: M(Apr 2) T(Apr 3) W(Apr 4) Th(Apr 5) F(Apr 6) M(Apr 9)

(per day) **AFTER CARE** \$20 x _____ = \$ _____

Please circle attending days: M(Apr 2) T(Apr 3) W(Apr 4) Th(Apr 5) F(Apr 6) M(Apr 9)

REGISTRATION FEES & PAYMENT

TOTAL TUITION: + _____
TOTAL EZ CARE PACKAGE: + _____
DONATION TO SCHOLARSHIP FUND + _____
TOTAL REGISTRATION FEE _____

Round House Theatre will charge this amount to the credit card listed below.

(Please circle) Visa MasterCard American Express Discover Check/MO# _____ (payable to RHT)
Credit Card #: _____ Expiration Date: _____

Name as it appears on card: _____

Participant Name: _____

EMERGENCY CONTACT INFORMATION

Parent/Guardian: _____ Home Phone: _____ Cell Phone: _____

IF THE ABOVE LISTED PARENT/GUARDIAN IS NOT AVAILABLE IN AN EMERGENCY, PLEASE CONTACT THE FOLLOWING PEOPLE:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

THE FOLLOWING PEOPLE IN ADDITION TO THE ABOVE LISTED PARENT/GUARDIAN ARE AUTHORIZED TO PICK UP THE PARTICIPANT

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

HEALTH HISTORY *Please circle if applicable to the participant.*

ALLERGIES

Seasonal Allergies Sulfa Drugs Insect Stings Peanuts/Other Nuts Penicillin Dairy Other: _____

OTHER CONDITIONS

Heart Defect/Disease	Diabetes	Asthma/Respiratory Disorder	Seizures
Autism Spectrum Disorder	Counseling or Therapy	Language Based Learning Disorder	ADD/ADHD
Bleeding/Clotting Disorder	Fainting/Dizziness	Non-Verbal Learning Disorder	Hypertension

Other: _____

PLEASE ATTACH EXPLANATIONS, IF NEEDED, AND INDICATE ANY OTHER SPECIAL CONSIDERATIONS
Round House Theatre is committed to complying with the Americans with Disabilities Act (ADA). If any auxiliary aids or services are needed in order to participate, notification must be received no later than two (2) weeks prior to the start of the program.

Describe any disability, illness or other medical concerns (including operations) that may affect the program participant:

Please list any medications and dosages your child is currently taking:

IF MEDICATION MUST BE DISPENSED BY OUR STAFF DURING PROGRAM HOURS A PHYSICIAN'S NOTE AND INSTRUCTIONS MUST ACCOMPANY THE MEDICATION

NAME OF PHYSICIAN: _____ PHONE: _____

NAME OF MEDICAL/HOSPITAL INSURANCE: _____ CARRIER ID POLICY #: _____

Participant Name: _____

POLICIES AGREEMENT

- The information I have provided on this is correct as far as I know, and the person herein described has permission to engage in all prescribed program activities except as noted.
- I understand payment is due in full at time of registration. Payment can be made by credit card, check, or cash. Make checks payable to Round House Theatre. A \$25 fee will be assessed on returned checks. EZ Care must be purchased before students are to receive care. EZ Care is non-refundable and non-transferable.
- I understand a full refund will be made when a program is cancelled due to insufficient enrollment. A 50% refund is available if the participant is withdrawn at least one month prior to the start date of the program. No refunds will be made within a month's time of a program's scheduled start date and/or after a program has begun.
- In the event that I cannot be reached in an emergency, I hereby give my permission to Round House Theatre to secure and administer treatment, including hospitalization, for the participant as named on this form. I understand that Round House Theatre cannot administer over-the-counter or prescription drugs to my child, unless this medication is sent in a properly labeled container provided by a pharmacy and accompanied by written authorization from the prescribing physician. I hereby authorize the staff of Round House Theatre to administer medical treatment if required.
- The participant as named on this form has permission to participate in all Round House Theatre activities unless I notify the Program Manager otherwise in writing.
- I understand Round House assumes no liability for injuries or damages arising from participation in any class or program. Due to the strenuous nature of some activities, the participant, and if applicable, the participant's parent/guardian, are urged to consult a physician concerning fitness to participate.
- Round House Theatre has my permission to use the name and/or image of participant as named on this form in publicity about Round House Theatre.

I have read, understood, and agree to the POLICIES, AUTHORIZATION OF MEDICAL TREATMENT AND AUTHORIZED PICK-UP information listed on this form

Name: _____

Parent Guardian
(Please circle)

Signature: _____ Date: _____

Return completed registration form to Round House Theatre Education Center by
fax | 301.585.9696
mail | 925 Wayne Avenue, Silver Spring, MD 20910
email (preferred method) | registration@roundhousetheatre.org

Questions?

Contact Round House Theatre Education Center
301.585.1225 | education@roundhousetheatre.org