

**2010 Youth Theater Day Camp**  
**June 14, – July 11 2010**  
**Registration**

Complete and mail to:  
The Ross Ragland Theater, Attn: H. Douglas Hite  
218 North 7<sup>th</sup> Street, Klamath Falls, OR 97601  
Or FAX: 541-884-8574

**Student's Name:** \_\_\_\_\_ **Age:** \_\_\_\_ **DOB:** \_\_\_\_\_

**School:** \_\_\_\_\_ **Grade:** \_\_\_\_ **Gender:** M F

**Parent(s)/Guardian(s):** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home Phone:** (\_\_\_\_) \_\_\_\_\_ **Cell Phone:** (\_\_\_\_) \_\_\_\_\_

**Work Phone:** (\_\_\_\_) \_\_\_\_\_ **Email Address:** \_\_\_\_\_

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**Tuition & Payment Information:**

**Grades 4 – 12**

**Tuition: \$ 325**

**Additional Sibling: \$ 300**

**Grades K – 3 (1/2 Day)**

**Tuition: \$ 175**

**Additional Sibling: \$ 150**

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- **Non-refundable deposit of \$ 100 per family to reserve placement. Space Limited**
- **Balance due by Monday, June 14, 2010 to ensure participation.**
- **Balance is non-refundable after 4 pm on Monday, June 14, 2010.**

\_\_\_ **Check enclosed. (Make checks payable to The Ross Ragland Theater)**

\_\_\_ **Charge my:**

**Card Number:** \_\_\_\_\_ **Amount:** \$ \_\_\_\_\_ **Exp. Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

The Ross Ragland Theater

## Emergency Contact and Medical Information

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: M F  
Parent's/Guardian's Name (print) \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

### Alternative Emergency Contacts

Primary Emergency Contact: (print) \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Secondary Emergency Contact (print) \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_ Cell: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

### Medical Information

Hospital/Clinic Preference: \_\_\_\_\_  
Physician's Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Allergies/Special Health Considerations: \_\_\_\_\_

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I authorize all medical and surgical treatment, X-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment. This waiver applies only in the event that neither parent/guardian can be reached in the case of an emergency.

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Parent's/Guardian's Signature

Date