Camp Registration Form

$900.00 Tuition fee
Full payment is due by the Friday before the first day of camp

Student:
Nickname:

Last Name:_____First Name: _____Middle Intial_____
Students Age/DOB _____

Parent Guardian 1:
Last Name:_____First Name: _____Middle Initial_____
Home Phone: _____Cell Phone: _____ Work Phone: _____
Email: _____ Home Address: _____

Parent Guardian 2:
Last Name:_____First Name: _____Middle Initial_____
Home Phone: _____Cell Phone: _____ Work Phone: _____
Email: _____ Home Address: _____

Emergency Contact:
Last Name:_____First Name: _____Middle Initial_____
Home Phone: _____Cell Phone: _____ Work Phone: _____
Email: _____ Home Address: _____

Authorized to pick up:

1. _____ 2. _____ 3. _____

Campers allergies/medical conditions or/and any other information you would like to share with us about your child:

_____
_____

Non-refundable deposit $ 100.00 ☐ **Cash** ☐ **Credit Card** ☐ **Check (Payable to Pinnacle Venue Services)**

☐ **Amex** ☐ **VISA** ☐ **MasterCard (Subject to a 3% charge)**

Credit Card Number: _____ Expiration Date: _____
CVV CARD #_____
Billing Address: _____

Parent / Guardian Signature: _____ Print Name: _____

Medical Release Form

Name of Child _____
Age: _____ **Date of Birth:** _____

I/We agree the undersigned parent(s) or legal guardians(s) of the above named-minor, acknowledge that I/We may not be available to authorize medical care of said minor child and wish to appoint someone to act in my place in my absence and give such authorization is intended to give (Seminole Theatre) staff the right to give consent to authorize emergency medical care.

It is intended that this document be presented to the physician or appropriate hospital or medical representative at such time as the medical care shall be authorized. It is intended that the authorization relieve the physician, dentist, person rendering such care at the hospital or institution in which such care is given from any liability resulting from the failure of me, the parent or guardian of the above-names minor, from signing a consent or authorization to render such care. It is the intent the Seminole Theatre shall act in my stead ion making decisions.

I have put the important medical facts, if any, on this form. The medical facts are intended to help the doctor in deciding what treatments to be given, but are in no way intended to restrict the giving of authorization or consent by Seminole Theatre. I understand that this form is in effect from the date signed and that is my responsibility to inform the Seminole Theatre of any changes in this form.

Parent / Guardian Signature #1: _____ **Print Name:**

Last Name:_____**First Name:** _____**Middle Initial**_____
Home Phone: _____**Cell Phone:** _____ **Work Phone:** _____

Parent / Guardian Signature #2: _____ **Print Name:**

Last Name:_____**First Name:** _____**Middle Initial**_____
Home Phone: _____**Cell Phone:** _____ **Work Phone:** _____

Pediatrician's Name: _____ **Phone Number:** _____

Hospital Preference: _____ **Phone Number:** _____

Full Address: _____

Insurance Company: _____**Policy Group:** _____

Date of Minors last tetanus shot: _____

Current Medications_____

Allergies: _____
Medical history we should know: _____

Release of Liability Form

I, the undersigned parent/legal guardian of _____

Understand that I have the responsibility to disclose any medical information that would preclude my child from participating in Seminole Theatre Camp program. I agree to hold Seminole Theatre Center, their agents, and employees harmless if ill disclosure of preexisting medical condition has not been provided.

I hereby release The Seminole Theatre Center from any and all claims for injuries to my child and/or loss of damage to his/her property, which may result from his/her participation in the program.

I agree that I shall hold The Seminole Theatre, their agents and employees harmless from any claims for injuries and/or damage to third parties on their property arising from the negligent or willful misconduct of my child.

I give permission to provide emergency medical care, hospitalization, or other treatment which may become necessary in the event of illness or injury.

Parent / Guardian Signature #1: _____ Print Name:

Parent/Legal Guardian Print Name: _____

Authorization for Photography/Video

I, the undersigned parent/legal guardian of _____

Hereby authorize and give consent to service and the staff of Seminole Theatre as follows:

I hereby: ☐ **Consent and authorize** **OR** ☐ **Do not consent and authorize**

The staff of Seminole Theatre to take/use still photographs, digital photographs, motion pictures, television transmission, and/or videotaped recordings (hereinafter "recordings of me, my children or my wards for educational, research, documentary, marketing and public relations purposes.

- **Any such recordings may reveal your identity through the image itself without any compensations to you, your child or wards.**
- **And all recordings taken of you, your children or wards shall be the sole property of Seminole Theatre.**
- **With Regard to the use of any recordings taken of you, your children, or wards, you hereby waive any and all present and future claims you may have against Seminole Theatre, their staff, service provides, employees, agents affiliates and board members.**

Parent / Guardian Signature #1: _____ Print Name:

Parent/Legal Guardian Print Name: _____

WAIVER FOR MINORS

(By Adult)

As the parent or guardian of a minor child participating in any program or activities or using any facilities, premises or equipment of the Seminole Theatre (the "City") referred to herein as ("the Indemnitees") or participating in any field trips arranged by any of the Indemnitees, I hereby waive any claim against the Indemnitees and their agents, servants and employees, hereafter arising from injuries to said child, which said injury is sustained while upon said facilities or premises, using such equipment, participation in said programs, activities or field trips or being transported therefrom or thereto, regardless of whether such injury is caused in whole or in part by the negligence of said Indemnitees or by the negligence of the agents, servants or employees of the Indemnitees, and I do covenant to indemnify, hold harmless and defend the Indemnitees, their agents, servants an employees from any claim, liability or damages hereafter arising out of any injury to said child, regardless of whether such injury to said child is caused in whole or in part by the negligence of said Indemnitees or by the negligence of the agents, servants and employees of the Indemnitees.

I hereby give permission for the Seminole Theatre to call my physician and /or arrange for the transportation to a hospital, in the event of any injury to said child, although I understand that the Seminole Theatre assumes no responsibility to do so. Further, I understand that the Seminole Theatre is not responsible for money, personal items, etc., lost during the program, activities or field trips and may discourage registrants from bringing such items.

Signature of Parent or Guardian: _____

_____

Name (print)

The Children's Trust

CHILD INFORMATION FORM

Child's Last Name _____ **First** _____ **Middle Name** _____

Child's Date of Birth (MM/DD/YYYY) ☐☐ ☐☐ ☐☐☐☐ **Child's Gender** ☐ Male ☐ Female

Last four (4) digits ONLY of child's social security # ☐☐☐☐ ☐ No SS #

Miami-Dade County Public Schools ID # ☐☐☐☐☐☐☐ ☐ No M-DCPS ID #

Child's current school _____

Is your child proficient in English? ☐ Yes ☐ No

Other language(s) spoken in your home ☐ Spanish ☐ Haitian Creole ☐ Other:_____ ☐ None

Street Address _____ **City** _____ **Zip Code** _____

Child's ethnicity ☐ Hispanic ☐ Haitian ☐ Other, please specify: _____

Child's race (select only one) ☐ American Indian or Alaskan ☐ Asian ☐ Black or African-American ☐ Pacific Islander ☐ White ☐ Other ☐ Multiracial

Child's current grade ☐☐

Does child have health insurance? (ex., private insurance, KidCare, Medicaid) ☐ Yes ☐ No
(If not, we may be able to help you find affordable coverage – call 211 or visit www.thechildrenstrust.org/parents/health-connect/insurance.)

Child's primary caregiver (full name) _____

Primary caregiver email address _____

Primary Phone Number ☐☐☐ ☐☐☐ ☐☐☐☐ **Is this a cell/mobile phone?** ☐ Yes ☐ No

(Please note that The Children's Trust may contact you via postal mail, email and/or text to ask about your satisfaction with these services, and to make you aware of other Trust-funded programs, initiatives and events you may be interested in.)

We want to get to know your child better so that we can provide the best possible experience in our programs. Please tell us more about your child…

What are the main ways in which your child communicates? (Mark all that apply)

- ☐ Speaks and is easily understood
- ☐ Speaks but is difficult to understand
- ☐ Uses communication devices like pictures or a board
- ☐ Uses gestures or expressions like pointing, pulling, smiling, frowning or blinking
- ☐ Uses sign language
- ☐ Uses sounds that are not words like laughing, crying or grunting

What, if any, help does your child receive at this time? (Mark all that apply)

- ☐ Behavioral therapy or services
- ☐ Counseling for emotional concerns
- ☐ Daily medication (not including vitamins)
- ☐ Occupational therapy (OT)
- ☐ Physical therapy (PT)
- ☐ Special education services in school
- ☐ Speech/language therapy
- ☐ None of the above

What conditions does your child have that are expected to last for a year or more? (Mark all that apply)

- ☐ Autism spectrum disorder
- ☐ Developmental delay (only if under age 5)
- ☐ Intellectual/developmental disability (over age 5)
- ☐ Hearing impairment or deaf
- ☐ Learning disability (school age)
- ☐ Medical condition or illness
- ☐ Physical disability or impairment
- ☐ Problems with aggression or temper
- ☐ Problems with attention and hyperactivity (ADHD)
- ☐ Problems with depression or anxiety
- ☐ Speech or language condition
- ☐ Visual impairment or blind
- ☐ None of the above

If you marked "None of the above" on the previous question, please skip the next two questions and sign below. If you marked any other answer on the question above, please answer the remaining questions and sign below.

Do any of the conditions marked above make it harder for your child to do things that other children of the same age can do? ☐ Yes ☐ No

To support your child's successful participation in this program, in what areas might s/he need extra assistance? ☐ No specific help needed

- ☐ Holding a crayon/pencil, writing, using scissors or other fine motor tasks
- ☐ Sports or physical activities like running or other gross motor tasks
- ☐ Managing feelings and behavior
- ☐ Academic, learning or reading activities
- ☐ Adapting activities to take into account a visual or hearing impairment
- ☐ Using assistive device(s) like a wheelchair, crutches, brace or walker
- ☐ Personal services like help with feeding, toileting or changing clothes
- ☐ Other _____

Please tell us anything else you think it is important for us to know about your child:

_____

If you are interested in other services funded by The Children's Trust, please call 211 or visit www.thechildrenstrust.org. For special needs resources for your child, visit www.advocacynetwork.org or www.thechildrenstrust.org/cwd

I give my permission for this information to be submitted to The Children's Trust for program quality and evaluation purposes. The Children's Trust provides funding for the program.

PARENT/GUARDIAN SIGNATURE _____ **DATE**_____

FOR STAFF USE ONLY (*MUST BE COMPLETED*)

ORGANIZATION _____ SITE _____

POPULATION MEMBERSHIP (check all that apply): ☐Dep Syst ☐Delin Syst

The Advocacy Network on Disabilities

"Getting to Know Me"

Child's Name _____

D.O.B. _____ Date _____

We want to get to know your child better so that we can provide the best possible educational experience. No one knows your child better than you. Tell us more about your child.

1. We want to know about your child's favorite/least favorite toys/activities/rewards:

Favorite	Least favorite
_____	_____
_____	_____
_____	_____

2. What calms your child and what upsets your child?

Calms	Upsets
_____	_____
_____	_____
_____	_____

3. How does your child communicate?

❑ Verbally ❑ Through gestures (i.e., pointing, pulling, blinking) ❑ American Sign Language (ASL)
❑ With vocalizations ❑ With communication devices (i.e., pictures)
❑ Other (please specify) _____

4. What services does your child receive?

❑ Speech/Language Therapy ❑ Behavioral ❑ Physical Therapy
❑ Mental Health Counseling ❑ Occupational Therapy ❑ None

May we contact your service provider to better support your child? ❑ Yes ❑ No (Signed authorization form required)

5. Does your child require assistive devices or equipment? (i.e., braces, walker, wheelchair, communication device, insulin, nebulizer)
❑ Yes ❑ No If yes, please describe _____

6. Do you suspect your child has a hearing or vision problem? ❑ Yes ❑ No

If yes, please describe _____

7. Which statement best describes your child's ability to move from one activity to another?

❑ Easily moves from one activity to the other ❑ Needs assistance to move from one activity to the other

Please explain _____

8. Does your child play/interact best (please check all that apply):

❑ Independently ❑ With another child ❑ Small group ❑ Large group ❑ Outdoor
❑ Indoor ❑ With adults ❑ Additional comments: _____

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The Children's Trust

The Advocacy Network on Disabilities

"Getting to Know Me"

Child's Name _____

D.O.B. _____ Date _____

9. Do any of the following bother your child?

❑ Noise ❑ Texture (i.e., sand, water) ❑ Lights ❑ Touch (i.e., hugs)
❑ Smells ❑ Other _____

10. Does your child wander, run away or bolt? ❑ Yes ❑ No

If yes, what situations precede this behavior? _____

11. Is your child able to do the following activities by him/herself?

Use the toilet ❑ Yes ❑ No Walk/move about ❑ Yes ❑ No
Eat ❑ Yes ❑ No Wash his/her hands ❑ Yes ❑ No

If no, please describe what assistance is needed: _____

12. Does your child take medication? ❑ Yes ❑ No

Medication side effects staff should be aware of: _____

Is there anything else you would like to share about your child (i.e., allergies, diet, seizures, nosebleeds)?

_____

_____

_____

_____

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