2018 Georgia Thespians Agreement Form

Georgia Thespians requires that this form be completed in full for each delegate (students and adults) attending any Georgia Thespians event and signed by the Attendee, a parent or legal guardian, and the Director. **Please type or print legibly in black or blue ink - No pencil or neon/bright colors. All forms must photocopy clearly.**

THE SUPER SIXTEEN: EVERY ATTENDEE (STUDENT AND ADULT) ***MUST SUPPLY ACCURATE INFORMATION FOR ALL OF THE SUPER 16 BOXES BELOW. DO NOT LEAVE ANY BOXES BLANK OR WRITE ANYTHING OTHER THAN THE INFORMATION REQUIRED.***

1) LAST NAME	**2) FIRST NAME**	**3) DATE OF BIRTH** (mm/dd/yyyy)
4) STREET ADDRESS (Home)		**5) PRIMARY TELEPHONE** (All 10 digits)
6) CITY	**7) STATE**	**8) ZIP**
9) SCHOOL NAME		**10) TROUPE NUMBER**
11) NAME OF PARENT or GUARDIAN or NEXT OF KIN and PRIMARY EMERGENCY CONTACT (First and Last names)	**12) RELATIONSHIP** TO ATTENDEE	**13) PHONE NUMBER** (All 10 digits)
14) SECONDARY EMERGENCY CONTACT (First and Last names) Cannot be the same as Primary Contact.	**15) RELATIONSHIP** TO ATTENDEE	**16) PHONE NUMBER** (All 10 digits)

NOTE: GIVE THE NAME AND PHONE NUMBER OF PHYSICIAN OR WITE THE WORD "NONE" IN EACH BOX. DO NOT LEAVE EITHER BOX BLANK. IF YOU LIST A PHYSICIAN, YOU MUST ALSO LIST A PHONE NUMBER.

FAMILY PHYSICIAN	**PHYSICIAN'S PHONE NUMBER** (All 10 digits)

THE MEDICAL THREE : EVERY ATTENDEE (SUDENT AND ADULT) ***MUST COMPLETE ALL THREE BOXES IN SECTION 2, even if the answer is "NONE."***

1) ALLERGIES TO FOOD AND/OR MEDICATIONS (If NONE, INDICATE BY WRITING THE WORD NONE. DO NOT LEAVE BLANK.)

2) MEDICATIONS YOU ARE CURRENTLY TAKING (If NONE, INDICATE BY WRITING THE WORD NONE. DO NOT LEAVE BLANK.)

3) SPECIAL MEDICAL PROBLEMS/PAST ILLNESSES/INFORMATION NECESSARY IN AN EMERGENCY (If NONE, INDICATE BY WRITING THE WORD NONE. DO NOT LEAVE BLANK)

I. CONSENT TO MEDICAL TREATMENT
The undersigned hereby gives permission and consent to Georgia Thespians and its Organizers to supervise/allow the self-administration of over-the-counter and prescription medications and to seek medical assistance and/or treatment on behalf of the Delegate in the event that an illness or injury requiring such medical assistance and/or treatment occurs while the Delegate is attending or participating in a Georgia Thespians event. In the event that reasonable attempts to contact the individuals listed above are unsuccessful, the undersigned hereby authorizes and consents to (1) the administration of any treatment deemed necessary by the physician listed above or, if unavailable, such other licensed physician or other healthcare provider as may be available and (2) the transfer of the Delegate to the nearest hospital or other medical facility for emergency medical evaluation, care and treatment. The indemnification in Section II below shall expressly cover any claims related to the actions by Georgia Thespians and its Organizers in (1) providing supervision and (2) seeking such medical evaluation, care and treatment, and in providing any information reasonably requested by such emergency medical providers for purposes of providing or billing for services.

II. RELEASE & INDEMNIFICATION
The undersigned hereby releases and agrees to indemnify, save and hold harmless Georgia Thespians, the Educational Theatre Association, its programs, Chapter and other Group Affiliates, and all respective officers, employees, agents and representatives of the aforementioned entities (each an "Organizer" and collectively the "Organizers") from and against any and all claims, demands, causes of actions, losses, liabilities, judgments, damages, costs and expenses (including reasonable attorneys' fees) resulting from the Delegate listed above participating in a Georgia Thespians event. The undersigned shall give each Organizer prompt written notice of any claim or facts or circumstances that might give rise to any claim for indemnification. The undersigned further agrees to be responsible for Delegate while traveling to and from a Georgia Thespians event including any expenses incurred by the Delegate, caused by the Delegate and/or any personal injuries which may occur to the Delegate. The undersigned authorizes the Delegate to be released to the Troupe Director or Chaperone listed on this form.

III. RULES AND REGULATIONS
The undersigned agrees that the Delegate shall abide by Georgia Thespians' security rules and regulations. The undersigned understands that, if the Delegate violates security rules and regulations, the Delegate may be returned home, and the undersigned (or parents and/or legal guardians) may be financially responsible for all necessary costs incurred while sending the Delegate home and no refunds will be granted.

IV. PHOTO/VIDEO RELEASE
The undersigned irrevocably consents to being photographed or being recorded by means of video or audio tape recording by the Organizers, or a designated representative of the Organizers. These photographs and/or recordings can be used, without compensation to undersigned and/or the Delegate, in any public display, publication or media, or website, or in any manner or form, and at any time by the Organizers in promotion of the mission to promote the theatrical arts and have theatre arts recognized in all phases of education. The undersigned releases the Organizers, and their employees, agents, representatives, associates, Board of Director members, and consultants from any liability in connection with the use of such photographic, video and/or audio materials.

V. AUTHORIZATION
I consent to the use or disclosure of protected health information by the Georgia Thespians or its Organizers, or any third party health care provider, for the purpose of analyzing, diagnosing, and providing treatment to the above stated Delegate, obtaining payment for healthcare services rendered or to be rendered, or to conduct healthcare operations. A copy of this consent is as valid as the original. I authorize my insurance benefits to be paid directly to the Georgia Thespians or its Organizers, or any third party healthcare provider. I assume full responsibility for and agree to pay for all services rendered or to be rendered. I understand I have a right to receive a copy of this consent upon request, and to revoke this consent in writing at any time except to the extent that the Organizers, or another third party healthcare provider has taken action in reliance on this consent. This authorization is valid one year from the date signed or through the term of coverage of the policy, and during the required period to process the claims.

VI. NON-REFUNDABLE FEES
The undersigned acknowledge that all conference–related fees are non-refundable.

The Delegate, the Delegate's parent and/or legal guardian, and Director have read, understand and agree to be bound by the above provisions, as evidenced by their signatures below.

PRINT NAME OF STUDENT/ADULT ATTENDEE	**SIGNATURE OF STUDENT/ADULT ATTENDEE**	**DATE**
PRINT NAME OF PARENT/GUARDIAN OF STUDENT (Adult attendees leave blank)	**SIGNATURE OF PARENT/GUARDIAN OF STUDENT (Adult attendees leave blank)**	**DATE**
PRINT NAME OF TROUPE DIRECTOR	**SIGNATURE OF TROUPE DIRECTOR**	**DATE**

THE OPTIONAL TEN: THE 10 BOXES BELOW ARE NOT REQUIRED BUT ARE STRONGLY RECOMMENDED TO EXPEDITE EMERGENCY SITUATIONS.

1) HEALTH INSURANCE COMPANY	2) HEALTH INSURANCE POLICY ID #	6) PRESCRIPTION PROVIDER NAME	7) PRESCRIPTION PROVIDER PHONE #
3) HEALTH INSURANCE GROUP/PLAN #	4) HEALTH INSURANCE PHONE #	8) PRESCRIPTION RX GROUP #	9) PRESCRIPTION RX BIN #
5) HEALTH INSURANCE POLICY HOLDER NAME		10) PRESCRIPTION ID #	