SHOWSTOPPERS SUMMER MUSICAL THEATRE CAMP
The Addams Family young@part

CHILD'S NAME:_____**BIRTH DATE:**_____

PARENT'S NAME:_____**CELL#**_____

PARENT'S NAME:_____**CELL#**_____

EMAIL ADDRESS:_____

EMERGENCY CONTACTS:

1. **NAME**:_____**CELL#**_____
2. **NAME:**_____**CELL#**_____

CHILD PICK UP: (Please list below the people who are permitted to pick up your child)

1. **NAME:**_____**CELL#**_____
2. **NAME:**_____**CELL#**_____

***If your child has any allergies or health issues please specify:**

_____

In case of accident or illness, I request that NYPAC contact me. If I am unable to be reached, as well as my Emergency Contacts, I hereby authorize NYPAC to call the physician indicated and to follow their instructions. If unable to contact the physician, the representative of the program may make whatever arrangements necessary. All the information below is accurate and complete. I hereby consent and authorize the necessary procedures stated above.

Physician's Name:_____ **Phone:**_____

Parent Signature:_____ **Date:**_____

PHOTO RELEASE: I hereby consent and authorize the use and reproduction of my child's image in print, video, or electronic format by NYPAC:

Parent Signature:_____**Date:**_____

By signing below I acknowledge that I am aware that the payment of $850.00 is non refundable:

Signature:_____**Date:**_____

PAYMENT: Cash:_____ Check *(made out to NYPAC)*: _____ VISA OR MASTERCARD _____

CC#_____EXP. DATE:_____ZIP CODE:_____