For Office Use: Deposit Paid _____ on_____

Full Tuition Paid _____ on _____

2025 BARNSTORMERS THEATRE YOUTH SUMMER CAMP REGISTRATION

112 NE Evelyn Ave. Grants Pass, OR 97526
541.479.3557

Tuition: $650

Limited partial scholarships available
Scholarship applications available upon request. Email barnstormersgp@gmail.com

Submit this form with full tuition **or** a **$100/per camper** non-refundable deposit
to Barnstormers Theatre by June 1st

- **MAIL IN/DROP OFF** cash or check with application to Barnstormers

or

- **EMAIL** forms to barnstormersgp@gmail.com
- **CALL** for cc/debit payment 541-479-3557

Camp Dates: June 30th -July 27th 2025 MONDAY - FRIDAY 9AM (8:45 drop off) - 3 PM pick up
Camp Shows :Friday July 25 6pm Saturday July 26th 6pm Sunday July 27th 2pm

NAME OF CAMPER(s) _____ _____

PREFERRED NAME (nickname) _____ _____

AGE (as of June 30th, 2025) _____ _____

T Shirt size _____ _____

ALLERGIES_____ _____ _____

Any Medications to be given by camp staff during camp hours? Y/N

Any Medications that your child takes independently during camp hours? Y/N

If yes to either, please complete one of corresponding attached forms

PARENT/GUARDIAN NAME(S)

_____ _____

PHONE#1_____ Text Y/N Email_____

PHONE#2_____ Text Y/N Email_____

Emergency Phone during camp hours_____

MAILING ADDRESS_____

EMERGENCY CONTACT(if you cannot be reached)

_____

PHONE_____

Is there anything we should be aware of regarding your child's behavior and/or physical, emotional or mental wellbeing?

_____

_____

By signing below I agree to pay the balance of tuition on or before the first day of camp my child(ren) attends.

Signature: _____ Date _____

PERMISSION TO PHOTOGRAPH

Occasionally,Barnstormers Theatre program activities may be photographed, videotaped, or audio taped for educational, publicity or fundraising purposes. Please indicate if you give permission for your child to appear in videos, photos or audio recordings without compensation (e.g., as part of brochures, slideshows or program websites).

___ Yes, I give my permission.

___ No, I do not want to appear in a photograph or videotape.

Date:_____

Parent/Guardian Signature:_____

Barnstormers Theatre Inc.

Authorization for Medication Administration

Child's Name:_____ DOB:_____

Production/Program:_____

I am giving Barnstormers Personnel and/or Barnstormers Staff permission to administer medications to my child per the following:
Medication:_____ ❑ Non Prescription

Dose (how much):_____❑ Prescription Rx number:_____

Frequency (how often):_____

By: Mouth Ear Eye Nose Skin (topical)

Time: Duration: Start date:_____End date: _____

Special Instructions:_____

_____

I understand I am responsible to provide this medication in its original (prescription or non-prescription) labeled container and maintain the supply as needed. I understand that I must deliver this medication to Barnstormers Theatre. I understand I am responsible to notify the organization of any changes in writing, and obtain a new prescription labeled container if the prescription is changed. Parents are required to pick up all unused medication by the last day of the production/program.. All medication left at the Barnstormers after this date _____ will be discarded.

Parent/Guardian Signature: _____ Date:_____

This authorization applies only to the medication listed above and for the duration of treatment or production/program. This also authorizes an exchange of information, as necessary between production staff and employees of Barnstormers and/or my child's health provider.

PHYSICIAN DIRECTION
(Required in writing or on pharmacy label for all prescription medications)

I have prescribed the above medication for the child whose name appears at the top of this form. Instructions in the box are accurate.
Physician's Name (print/stamp)_____ Phone:_____

Physician Signature: _____

Effective Date: _____

BARNSTORMERS THEATRE Inc.

CHILD SELF ADMINISTRATION OF MEDICATION AUTHORIZATION & AGREEMENT

Child's Name _____ DOB_____

Medication Name:_____ Dose_____

Children who are developmentally and/or behaviorally able, will be allowed to self administer prescription and nonprescription medication, subject to the following:

1. Permission form must be submitted for all self-medication of all prescription and nonprescription medication.

2. All prescription and nonprescription medication must be kept in its appropriately labeled, original container, as follows:

- Prescription labels must specify the name of the child, name of the medication, dosage, route, and frequency or time of administration and any other special instructions.
- Non prescription medication must have the child's name affixed to the original container

3. The child may have in his/her possession only the amount of medication needed for that rehearsal and/or program day.

4. Sharing and/or borrowing of medication with another child is strictly prohibited.

5. Permission to self-medicate may be revoked if the child violates administration of medication and/or these regulations. Additionally, children may be subject to discipline, up to and including removal from a production or program.

I have read and agree to the above criteria and give permission for my child to carry the above medication.

Parent/Guardian Signature:_____ Date_____

I agree to comply with the above criteria.

Child Signature_____ Date_____

Medication Authorized By: _____
Physician Name (print/stamp)

I have prescribed the above medication for the child whose name appears at the top of this form.

Physician Signature:_____ Date _____

Approved By: _____ Date_____
(Barnstormers Staff)