



**Educational  
Theatre  
Association™**

**Arkansas**

## 2024-25 Chapter Consent and Acceptance form

The Arkansas Chapter of the Educational Theatre Association requires that this form be completed in full for each delegate (students and adults) attending AR Thespian Festival and signed by a parent or legal guardian. Type or print legibly. Enter Delegate's name exactly as it appears on registration form. **Upload to the shared folder by (12/6/2024).**

Check here if 18+ at time of Festival.

LAST NAME		FIRST NAME	MIDDLE NAME	DATE OF BIRTH	GENDER
STREET ADDRESS (Home)				PHONE NUMBER	
CITY		STATE		ZIP	
SCHOOL				TROUPE NUMBER	
NAME OF PARENT/GUARDIAN/NEXT OF KIN			RELATIONSHIP	PHONE NUMBER	
NAME OF EMERGENCY CONTACT (1)			RELATIONSHIP	PHONE NUMBER	
NAME OF EMERGENCY CONTACT (2)			RELATIONSHIP	PHONE NUMBER	
NAME OF TROUPE DIRECTOR OR CHAPERONE ATTENDING EVENT					

ALLERGIES TO FOOD AND/OR MEDICATIONS (IF NONE, please indicate)

MEDICATIONS CURRENTLY BEING TAKEN (IF NONE, please indicate)

PAST ILLNESSES OR INFORMATION NECESSARY IN AN EMERGENCY (IF NONE, please indicate)

### HEALTH INSURANCE COMPANY

INSURANCE COMPANY NAME

POLICY HOLDER NAME

POLICY ID#

GROUP/PLAN #

INSURANCE COMPANY STREET ADDRESS

CITY

STATE

ZIP CODE

PRESCRIPTION INSURANCE

PROVIDER NAME

PROVIDER PHONE NUMBER

Rx GROUP #

Rx BIN #

ID #

<b>FAMILY PHYSICIAN</b>		
NAME		
PHONE NUMBER		
STREET ADDRESS		
CITY	STATE	ZIP CODE

<b>I CONSENT TO A BACKGROUND CHECK (18+ years old)</b>	
<p>I understand my ability to participate in any program involving children as an Educational Theatre Association (EdTA) employee or volunteer may be contingent on the receipt and evaluation of my Background Check.</p> <p>Failure to provide consent will result in the denial of or termination of my participation in any program involving children.</p> <p>I understand that EdTA may obtain follow-up Background Checks at any time during my participation in such programs, to the extent permitted by law, unless I revoke this consent in writing. I understand that revocation of this consent may result in the immediate termination of my participation.</p> <p>I understand that any information obtained from a Background Check may be considered in the course of any current or future engagement, including employment, with EdTA.</p> <p>I understand that if the Background Check indicates that an outstanding warrant has been issued against me, EdTA will share that information with appropriate law enforcement agencies. I have read and understand all of the information above, and by my signature below, consent to and hereby grant authorization to obtain and release of the background check reports described above to EdTA within the terms of this Statement.</p>	
SIGNATURE of person 18+	DATE

<b>I DO NOT CONSENT TO MEDICAL TREATMENT</b>	
<p>The undersigned does not give permission or consent to the administration of any health care services (including routine first aid and supervision of the self-administration of medications) to the Delegate in the event of illness or injury requiring medical assistance and/or treatment. However, the undersigned acknowledges and agrees that EdTA Arkansas and its Organizers, expressly reserve the right to seek emergency medical care (including, without limitation, calling *911*), and the indemnification in Section I below shall expressly cover any claims related to the actions by EdTA Arkansas and its Organizers in seeking such medical care and in providing any information reasonably requested by such emergency medical providers for purposes of providing or billing for such care.</p>	
SIGNATURE	DATE

