



**Educational
Theatre
Association™**

Arkansas

2023-24 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 2023 and signed by a parent or legal guardian. Type or print legibly. Enter Delegate's name exactly as it appears on registration form. **Return by (1/09/2024).**

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 #

| | | |
|-------------------------|-------|----------|
| FAMILY PHYSICIAN | | |
| NAME | | |
| PHONE NUMBER | | |
| STREET ADDRESS | | |
| CITY | STATE | ZIP CODE |

| | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|
| I CONSENT TO A BACKGROUND CHECK (18+ years old) | |
| <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 |

| | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|
| I DO NOT CONSENT TO MEDICAL TREATMENT | |
| <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 |

I. RELEASE & INDEMNIFICATION

The undersigned hereby releases and agrees to indemnify, save and hold harmless EdTA Arkansas, 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 EdTA Arkansas. 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 EdTA Arkansas 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 Page 1 of this form.

II. RULES AND REGULATIONS

The undersigned agrees that the Delegate shall abide by EdTA Arkansas 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 Delegate home and no refunds will be granted.

III. 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.

IV. AUTHORIZATION

I consent to the use or disclosure of protected health information by the EdTA Arkansas 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 health care services rendered or to be rendered, or to conduct health care operations. A copy of this consent is as valid as the original. I authorize my insurance benefits to be paid directly to the EdTA Arkansas or its Organizers, or any third party health care 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 health care 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.

V. YOUTH ACTIVITY SAFETY POLICY

EdTA Arkansas has implemented a Youth Activity Safety Policy to provide a safe environment for youths participating in activities, clinics, and conferences. This policy will help to protect participating youths from potential misconduct incidents and help provide a safe, educational, and enjoyable activity/program experience.

The Delegate and the Delegate's parent and/or legal guardian has read, understands and agrees to be bound by the above provisions, as evidenced by their signature below:

| | | | |
|-------------------------------------|-------------|------------------------------|-------------|
| _____ | _____ | _____ | _____ |
| SIGNATURE OF PARENT/GUARDIAN | DATE | SIGNATURE OF DELEGATE | DATE |