



Office Use Only:

____ Date Rec'd

____ Full payment
Rec'd

2017

Summer Youth Musical Theatre Workshop

Application Form

PLEASE READ THIS APPLICATION CAREFULLY

Please complete the entire application and mail it along with your enrollment fee to:

Musicals at Richter, 100 Aunt Hack Road, Danbury, CT 06811

Student's Name _____

Preferred Name/Nickname _____ Gender: M/F

Date of Birth _____ Age as of June 2017 _____

What grade will you be going into in the 2017-18 School Year? _____

I would like my child to be placed in the same group as (must be in similar grade level or age): _____

Mailing Address _____

City _____ State _____ Zip _____

Name of Parent(s)/Guardian(s) _____

Mailing Address (if different from above) _____

City _____ State _____ Zip _____

Day phone # _____ Evening phone # _____

Cell phone # _____ Email address _____

Emergency information

Doctor's Name _____

Dr.'s Phone # _____

Do you have Health Insurance: Y/N

Company name _____

ID # _____

Parent/Guardian signature _____ Date _____

REFUND POLICY

There are no refunds for students dismissed from the program due to illness or disciplinary reasons, or for students that choose to leave the program early.

SUMMER YOUTH MUSICAL THEATER WORKSHOP PAYMENT FORM

I would like to enroll my child with Musicals At Richter SUMMER
YOUTH MUSICAL THEATER WORKSHOP!

Session 1: June 26th-July 21st

\$700 Paid by April 15, 2017

\$800 Paid after April 15, 2017

DEADLINE June 21st

*Prorating available for late school closings for
single session only.

Session 2: July 24th-Aug 18th

\$800 Paid by April 15, 2017

\$900 Paid after April 15, 2017

DEADLINE July 19th

| Session 1: June 26-July 21 (4 weeks) | <u># of</u> | <u>TOTAL</u> |
|--|-------------|-----------------|
| \$700 Single Child Before April 15 | _____ | x \$700 = _____ |
| \$800 Single Child After April 15 | _____ | x \$800 = _____ |
| \$595 Additional Sibling Before April 15 | _____ | x \$595 = _____ |
| \$680 Additional Sibling After April 15 | _____ | x \$680 = _____ |

| Session 2: July 24th -August 18 (4 weeks) | <u># of</u> | <u>TOTAL</u> |
|---|-------------|-----------------|
| \$800 Single Child Before April 15 | _____ | x \$800 = _____ |
| \$900 Single Child After April 15 | _____ | x \$900 = _____ |
| \$680 Additional Sibling Before April 15 | _____ | x \$680 = _____ |
| \$765 Additional Sibling After April 15 | _____ | x \$765 = _____ |

| Both Sessions: June 26-August 18 (8 weeks) | <u># of</u> | <u>TOTAL</u> |
|--|-------------|------------------|
| \$1,200 Single Child Before April 15 | _____ | x \$1200 = _____ |
| \$1,360 Single Child After April 15 | _____ | x \$1360 = _____ |
| \$1,020 Additional Sibling Before April 15 | _____ | x \$1020 = _____ |
| \$1,156 Additional Sibling After April 15 | _____ | x \$1156 = _____ |

TOTAL _____

We would appreciate checks payable to: **Musicals at Richter**

PAYMENT METHOD: ONLINE CHECK CASH (in person only)

Discounted rates will only be honored if full payment is received by the
discount cut off date. Payment Plans available upon request.

SIGNATURE: _____

**Musicals at Richter Summer Youth Musical Theater Workshop
MAR Kids Participant Medical History Report**

This form must be completed, signed and returned by parent or guardian. It is the aim of Musicals at Richter to have each participant enjoy as complete an experience as is possible within his/her capabilities. Your medical history will provide the essential information needed to meet this goal. The history is required primarily to determine what adjustments, if any, should be made in schedules of activities to meet the individual needs of participants, and that the participant may safely participate in those activities. **NOTE: MUSICALS AT RICHTER, THE DIRECTOR, AND ALL STAFF RESERVE THE RIGHT TO DETERMINE THE EXTENT OF PARTICIPATION OF EACH PARTICIPANT IN ALL ACTIVITIES CONDUCTED AT THE MUSICALS AT RICHTER SUMMER YOUTH MUSICAL THEATRE WORKSHOP.**

The CONFIDENTIAL information will also be used in the event of any participant injuries.

| | | | |
|---|--|---------------------|-------------------------|
| STUDENT (LAST NAME, FIRST, MIDDLE) PRINT | PARENT / GUARDIAN NAME | | |
| ADDRESS | STUDENTS AGE / BIRTHDATE | | |
| CITY, STATE, ZIP | <table border="0"> <tr> <td align="center">DAY PHONE ()</td> <td align="center">EVENING PHONE ()</td> </tr> </table> | DAY PHONE () | EVENING PHONE () |
| DAY PHONE () | EVENING PHONE () | | |

IN CASE OF EMERGENCY CONTACT (AVAILABLE 24 HOURS)

| | | |
|-----------------------------|--------------|---------------------|
| LAST NAME, FIRST, MIDDLE | RELATIONSHIP | TELEPHONE () |
|-----------------------------|--------------|---------------------|

PERSONAL HISTORY

Check box beside those medical problems camp participant has had or currently has.

- | | | |
|--|--|---|
| <input type="checkbox"/> Measles (Rubella) | <input type="checkbox"/> Kidney | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Rubella (3-day measles) | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Bladder problem | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Chicken pox |
| <input type="checkbox"/> Tension or depression | <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Frequent headaches |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Knee Sprains | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Hay fever, asthma |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Ear trouble | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Jaundice, liver disease | <input type="checkbox"/> Heart problem | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Stomach trouble | <input type="checkbox"/> Throat problems |
| <input type="checkbox"/> Eye trouble | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Back problem | <input type="checkbox"/> Joint problems |
| <input type="checkbox"/> Allergies (drugs/food) | <input type="checkbox"/> S T D's | <input type="checkbox"/> Gall bladder trouble |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hernia | <input type="checkbox"/> Sickle cell anemia |
| <input type="checkbox"/> Seizure / Epilepsy | <input type="checkbox"/> Neurological disorder | |
| <input type="checkbox"/> Ankle Sprains | <input type="checkbox"/> Knee Sprains | |
| <input type="checkbox"/> Mild | <input type="checkbox"/> Mild | |
| <input type="checkbox"/> Severe | <input type="checkbox"/> Severe | |

Other _____

Please list here any HOSPITALIZATION or OUT-PATIENT SURGERY camper has had within the past five years.

| Name of Hospital | City & State | Date | Type of illness or operation | Outcome |
|------------------|--------------|------|------------------------------|---------|
| | | | | |
| | | | | |
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