Camp CCYT presents We’re Off to See the Wizard!

Caryl Crane Youth Theatre is pleased to announce The Wizard of Oz as its 2017 summer camp offering! Explore all aspects of the theatre with other aspiring actors who love the stage as much as you do! Camp CCYT is the arts camp that is more than a traditional summer camp. Designed for students ages 10-18, the program is a comprehensive, one-week intensive, in which students get a chance to hone their skills in a fast-paced, creative environment.

Somewhere Over The Rainbow

Camp CCYT meets June 19-23, 2017, 9am – 3 pm in the McBride Auditorium on BGSU Firelands College Campus. One public performance of The Wizard of Oz is scheduled for Saturday, June 24 at 10 am.

In The Merry Old Land of Oz

Each student will not only STAR onstage in the production, but also will also contribute to the direction, choreography, set, lighting and costume design of the production. Students will be assigned a mentor from the Caryl Crane Youth Theatre 2017 Staff and will work as assistants on a specific “behind-the-scenes” area of their interest.

Follow the Yellow Brick Road

Camp CCYT is designed to instill in aspiring thespians a deeper understanding about producing and participating in a first-class musical with working professionals. Tuition for Camp CCYT is $125.00 and space is limited to 34 students. All interested campers are accepted on a first come basis and must audition for placement. Placement will take place Thursday, April 27, 5-7 pm in the McBride Auditorium at BGSU Firelands Colelge. For registration packets and to reserve your place in the camp, email carylcraneyouththeatre@gmail.com. Additional details will be emailed to all participants. For questions or more information, please call Caryl Crane Youth Theatre at 419.372.0732. See you at Camp CCYT!

Please fill out the following pages and return all forms with the $25 deposit* to:

Caryl Crane Youth Theatre
BGSU Firelands College
One University Drive
Huron, OH 44839

*The remaining $100 balance is due on the first day of camp, June 19th.
Camp CCYT 2017
To be filled in by Parent/Guardian of Camp CCYT 2017 Participant

Section 1
Student First Name: ___________________________ Student Last Name: ___________________________ MI: ______
Address: ________________________________________________________________________________
City: State: Zip: _________________________________________________________________________
Home Phone: ___________________________ Cell Phone: ___________________________ Birthdate: ___________
Student e-mail (required): __________________________________________________________________
Do you want to be on our mailing list?  ☐ Yes  ☐ No  Age: ___________
Grade / College Year Entering Fall 2016: ___________________________ School Attending: ________________
T-Shirt Size Requested: ___________________________

Section 2
Does your child have special needs?  ☐ Yes  ☐ No  If yes, please describe below:
Special Needs: ___________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

Is your child interested in onstage participation (actor), backstage participation (technical/designers) or production participation (assistant director, assistant choreographer)? Please circle all that apply.

Section 3
Family Status:  ☐ Married  ☐ Divorced  ☐ Separated  ☐ Widowed  ☐ Single
Parent with Custody:  ☐ Both Parents  ☐ Mother  ☐ Father  ☐ Other:
Father’s Full Name: ___________________________ Home Phone: ___________________________
Business Phone: ___________________________ e-mail: ___________________________
Father’s address (if different from child’s) ____________________________________________________________________________
City: ___________________________ State ___________ Zip ___________
Mother’s Full Name: ___________________________ Home Phone: ___________________________
Business Phone: ___________________________ e-mail: ___________________________
Mother’s address (if different from child’s) ____________________________________________________________________________
City: ___________________________ State ___________ Zip ___________

Please continue to the next page
PAYMENT OPTIONS  $125.00 ($25 of this is non-refundable) Select the payment option below that best meets your needs.

___ $25 is due with application. Remaining balance is due on June 19th at the first day of camp.

___ I wish to pay in full. I understand that $25 of the cost is a non-refundable security deposit.

Payment can be made by Check or Cash only.

- **Check:** (There is a $20.00 charge for insufficient funds using check.) Check for $ _____________ is enclosed.
- **Cash:** Cash Payments must be made on the audition day. DO NOT SEND CASH THROUGH THE MAIL.

RELEASE

• In consideration of being allowed to participate in Camp CCYT classes and activities, I acknowledge that I, as parent or guardian of the student under age 18, or I, as a student myself, voluntarily assume all risks of accident or damage to my person or property.
• I agree to abide by all rules and regulations and hereby release from clam, liability or demand, all employees, representatives, trustees and officers of Caryl Crane Youth Theatre, as well as their heirs, executors, administrators, successors and assigns for any personal injury or damage of any kind. I understand that the above-mentioned parties are not insurers of my personal safety during this Camp.
• Students photo and quotes may be used for media releases and other Caryl Crane Youth Theatre publicity purposes.
• I agree to allow Caryl Crane Youth Theatre to release my child’s name, address and phone number to other students and/or children within their group as part of a group roster.
• Caryl Crane Youth Theatre is not responsible for loss or damage to any child’s property during the Camp CCYT session.
• In the event of emergency, I authorize the Camp CCYT Director or staff to act for me according to their best judgment. I understand that payment for medical services is solely the family’s responsibility. **Note:** For child’s safety, medical consent forms must be received by Caryl Crane Youth Theatre prior to first day. Caryl Crane Youth Theatre will provide forms by mail or electronically (see medical form attached.)
• Registrations will only be processed with deposit and post-dated payments for remaining balance or full payment.
• If, for any reason Caryl Crane Youth Theatre suggests a student withdraw from Camp CCYT, a refund will be made for the for the unexpired days of the session. If child is withdrawn from Camp CCYT before the end of the session by parents, no refund will be made.
• I understand that Camp CCYT fees are NON-REFUNDABLE AND NON-TRANSFERABLE
• I understand that all payments include a $25.00 non-refundable registration deposit. If a registered student must withdraw, all monies will be refunded minus the registration deposit. (No refunds will be issued after June 19, 2017).
• This release is entered into freely and with full knowledge of its’ contents and effect and will operate for heirs, my executors, administrators, assigns and myself.

**YES, I HAVE READ AND UNDERSTAND THE INFORMATION ABOVE:**

Date: ______________ Please sign your name here: ________________________________

Please print your name here________________________________________________________

After signing, please fill in the medical release form and send the registration, medical release and payment to:

**CARYL CRANE YOUTH THEATRE**
**BGSU FIRELANDS COLLEGE**
**ONE UNIVERSITY DRIVE**
**HURON, OH 44839**

419-372-0732. For more information about Camp CCYT go to: www.firelands.bgsu.edu/ccyt

I would like to know more about getting involved in Camp CCYT and/or Caryl Crane Youth Theatre activities as a volunteer: Yes No Maybe

**OFFICE USE ONLY:**
Date Rec’d ________ Check No. ________ Amount __________ Cash Rec’d Amount _______

Posted __________ PC Pg/Ln ________ CL ________

NOTES:
BOWLING GREEN STATE UNIVERSITY
LIABILITY RELEASE, WAIVER, DISCHARGE AND AGREEMENT NOT TO SUE
For Minor Participation (Gr. K -12)

1. I desire that my child __________________ participate in the following activity/trip __________________ (“Activity”), to be held on ____________. I fully understand and appreciate the dangers, hazards, and risks inherent in the Activity, in the transportation to and from the Activity (if applicable), and in any activities undertaken supplemental to the Activity. These dangers and risks can result in injury and impairment to my body, general health, well being, and could include serious or even mortal injuries and property damage.

2. Knowing the dangers, hazards, and risks of such activities, and in consideration of being permitted to participate in the Activity, on behalf of myself, my family, heirs, and personal representative(s), I agree to assume all the risks and responsibilities surrounding my child’s participation in the Activity, the transportation, and in any activities undertaken as supplemental and to release, waive, forever discharge, and covenant not to sue the State of Ohio, Bowling Green State University, and its governing board, officers, agents, employees and any students acting as employees (“Releasees”), from and against any and all liability for any harm, injury, damage, claims, demands, actions, causes of action, costs, and expenses of any nature that I may have or that may hereafter accrue to me, arising out of or related to any loss, damage, or injury, including but not limited to suffering and death, that may be sustained by my child or by any property belonging to my child, whether caused by the negligence or carelessness of the Releasees, or otherwise, while in, on, upon, or in transit to or from the premises where the Activity, or any supplement to the Activity, occurs or is being conducted.

3. I understand and agree that Releasees are granted permission to authorize emergency medical treatment, if necessary, and that such action by Releasees shall be subject to the terms of this Agreement. I understand and agree that Releasees assume no responsibility for any injury or damage which might arise out of or in connection with such authorized emergency medical treatment.

4. It is my express intent that this release and hold harmless agreement shall bind myself, the members of my family and spouse, if I am alive, and my estate, family, heirs, administrators, personal representatives, or assigns, if I am deceased, and shall be deemed as a "Release, Waiver, Discharge and Covenant" not to sue the Releasees.

5. In signing this Release, I acknowledge and represent that I have carefully read this Agreement and understand its contents and that I sign this document as my own free act and deed. I further state that I am an adult and fully competent to sign this Agreement; and that I execute this release for full, adequate, and complete consideration fully intending to be bound by the same. I further state that there are no health-related reasons or problems which preclude or restrict my child’s participation in this activity, and that I have adequate health insurance necessary to provide for and pay any medical costs that may be attendant as a result of injury to my child.

6. I further agree that this Release shall be construed in accordance with the laws of the State of Ohio. If any term or provision of this Release shall be held illegal, unenforceable, or in conflict with any law governing this Release the validity of the remaining portions shall not be affected thereby.

THIS IS A RELEASE OF LEGAL RIGHTS. READ AND BE CERTAIN YOU UNDERSTAND IT BEFORE SIGNING.

Signature of Parent or Guardian:_________________________________________ Date:________________________

Print Name:__________________________________________________________

6/03 RM
MEDICAL HISTORY AND CONSENT FOR EMERGENCY MEDICAL TREATMENT

Directions: Parents of minors must complete this form for program staff to provide routine health care and seek emergency medical treatment. Please answer all questions. Please type or print in black ink. Attach any permission forms from your physician to dispense medication to this form. Incomplete forms will be returned.

PARTICIPANT INFORMATION

<table>
<thead>
<tr>
<th>Participant’s Name</th>
<th>Gender</th>
<th>Date of Birth</th>
<th>Age</th>
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<tr>
<th>Home Address</th>
<th>City/State/Zip</th>
<th>Name of Program Attending</th>
<th>Home Phone</th>
<th>Date</th>
<th>From</th>
<th>To</th>
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Overnight [ ] Yes [ ] No

EMERGENCY NOTIFICATION (PARENT OR GUARDIAN)

Before a participant under 18 years of age can be treated, the law requires us to obtain parent/guardian consent for treatment. Accordingly, for the safety and well-being of the participant, please provide us with as many phone numbers as possible.

PRIMARY CONTACT

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Relationship</th>
<th>Home Phone</th>
<th>Work Phone</th>
<th>Cell Phone</th>
<th>Email Address</th>
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SECONDARY CONTACT

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Relationship</th>
<th>Home Phone</th>
<th>Work Phone</th>
<th>Cell Phone</th>
<th>Email Address</th>
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PHYSICIAN INFORMATION

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<thead>
<tr>
<th>Family Physician</th>
<th>Address</th>
<th>Phone</th>
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SPECIALIST INFORMATION

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<th>Specialist Name</th>
<th>Address</th>
<th>Phone</th>
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DENTIST INFORMATION

<table>
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<tr>
<th>Family Dentist</th>
<th>Address</th>
<th>Phone</th>
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SPORTS CAMPS ONLY:

- Date of last physical examination
- Sport or activity cleared for:
- List any Restrictions

MEDICAL HISTORY – Please indicate if the participant has any chronic childhood conditions or diseases related to the following and list details, including any activity restrictions in the space provided.

- Arthritis & Rheumatologic Conditions
- Asthma
- Bones & Muscles
- Brain & Nervous System
- Cancer & Tumors
- Digestive System
- Ears, Nose, Throat/Speech, & Hearing
- Endocrine Glands, Growth, & Diabetes

- Genetic, Chromosomal, & Metabolic Conditions
- Heart & Blood Vessels
- Kidney & Urinary System
- Learning Disorders
- Lungs & Respiratory System
- Sexual & Reproductive System
- Skin Disorders
- Sleep Disorders

Details:
ALLERGIES - [ ] this person has no allergies OR [ ] this person has allergies as follows:

<table>
<thead>
<tr>
<th>TYPE (Insect, Food, Medications)</th>
<th>DESCRIBE REACTION</th>
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MEDICATIONS - [ ] this person takes no medications OR [ ] this person takes medications as follows:

<table>
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<tr>
<th>MEDICATIONS</th>
<th>DOSAGE</th>
<th>FREQUENCY</th>
<th>DIAGNOSIS</th>
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Note: Our program staff is unable to administer any medications, (prescription or non-prescription) to participants without a signed order by a licensed physician. The Permission to Dispense Medication by Camp Program Staff Form is available for this purpose. Parents or guardians may not send any prescription or over-the-counter medication to a participant that a physician has not signed for.

DISABILITY - Please indicate if participant is handicapped or disabled in any way: [ ] Psychological [ ] Neurological [ ] Hearing [ ] Pulmonary [ ] Learning [ ] Mobility [ ] Other

CURRENT MEDICAL CONDITIONS - Please indicate if participant currently has any medical conditions or limitations that do not constitute a handicap or a disability that would impair or limit the participant from fully engaging in the activities of the camp for which the participant is registering, and provide a complete description of such conditions or limitations:

MEDICAL INSURANCE INFORMATION - Is the participant covered by more than one health plan? [ ] Yes [ ] No

Name of Policyholder
Policyholder ID #
Policyholder Date of Birth
Relationship to Participant
Policyholder Phone
Medical Insurer Name
Plan Type
Insurer Address

Insurer Phone
Group Name
Group ID #

PLEASE PROVIDE A COPY OF THE FRONT AND BACK OF ALL INSURANCE CARDS AND PRESCRIPTION ID CARD.

Policyholder Carrier Name
Policyholder same as listed above? [ ] Yes [ ] No
Carrier Address
Carrier Phone
Group Name
Group ID #

IMMUNIZATIONS
The participant has been immunized in accordance with the recommended immunization schedules for children and adolescents approved by the CDC and The American Academy of Pediatrics [ ] Yes [ ] No. PLEASE NOTE: FOR PARTICIPANTS OF RESIDENTIAL CAMPS, A COMPLETE IMMUNIZATION RECORD IS REQUIRED.

CONSENT FOR MEDICAL TREATMENT
In the event reasonable attempts to contact me are unsuccessful, PERMISSION is hereby granted for the examination, treatment and medical care of the participant by the BGSU Student Health Service or another duly licensed healthcare facility. PERMISSION is also granted to execute on behalf of the participant any admission or consent forms needed to obtain such treatment. By signing below, I agree that I have read the foregoing and consent to the terms and conditions as stated.

Signature of Parent/Guardian
Print Name
Date

STAFF USE
Form Complete [ ] Yes [ ] NoReviewed by
Action Needed

University Records Retention Policies recommend that consent forms for minors be kept for a minimum of six years

Page 2 of 2
PERMISSION TO DISPENSE MEDICATION
BY CAMP PROGRAM STAFF

Directions: Under no circumstances will medication be dispensed without written permission on file. This includes any prescription, non-prescription or over-the-counter medications. It is preferred that medication be given at home whenever possible. If it must be given during camp, the following form must be completed. A separate form must be completed for each medication. Please type or print in black ink. Incomplete forms will be returned.

PARTICIPANT INFORMATION

Participant’s Name ____________________________
Date of Birth ____________________________
Home Address ____________________________
City/State/Zip ____________________________
Home Phone ____________________________
Total Number of Medications/Forms ____________________________

PHYSICIAN SECTION

Name of Medication ____________________________
Dosage ____________________________
Reason Taken ____________________________
Times Taken Each Day ____________________________
Date/Time to Begin Medication ____________________________
Date to Discontinue Medication ____________________________
Possible Side Effects ____________________________
Special Instructions ____________________________

Signature of Physician ____________________________
Print Name ____________________________
Date ____________________________

PARENT/GUARDIAN SECTION

I authorize program staff to administer this medication and agree to:

1. Send and maintain an adequate supply of the medication (appropriately labeled) to the camp session.
2. Assure that the medication is the one dispensed by the physician or pharmacist and labeled with the participant’s name, name of medication, dosage and time of administration.
3. Be advised that under no circumstances will medication be dispensed without written permission or without a container identifying the participant’s name, the name of the medication and the dosage. Verbal permission will not be acceptable at any time.
4. Be advised a new signed permission statement will be necessary for any change in physicians, dosage, medication or procedure change.

Signature of Parent/Guardian ____________________________
Print Name ____________________________
Date ____________________________

Apr. 08