2023-2024 Chapter Consent and Acceptance form

The WASHINGTON STATE THESPIANS requires that this form be completed in full for each delegate (students and adults) attending all Washington Thespian Events and signed by a parent or legal guardian. Enter Delegate's name exactly as it appears on registration form. ***Every attendee must complete and bring TWO COPIES to each live event.***

Please type or print legibly in black or blue ink.

LAST NAME	**FIRST NAME**	**MIDDLE NAME**	**DATE OF BIRTH** (mm/dd/yyyy)	**GENDER**
STREET ADDRESS (Home)			**TELEPHONE** (10-digit home or primary)	
CITY	**STATE**		**ZIP CODE**	
SCHOOL			**TROUPE NUMBER**	
NAME OF PARENT/GUARDIAN/NEXT OF KIN (First and last name)	**RELATIONSHIP**		**PHONE NUMBER** (10-digit)	
PRIMARY EMERGENCY CONTACT (First and last name)	**RELATIONSHIP**		**PHONE NUMBER** (10-digit)	
SECONDARY EMERGENCY CONTACT (First and last name)	**RELATIONSHIP**		**PHONE NUMBER** (10-digit)	
NAME OF TROUPE DIRECTOR OR CHAPERONE ATTENDING EVENT (Chaperone must be 21 years or older)				

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)

I CONSENT TO MEDICAL TREATMENT

The undersigned hereby gives permission and consents to International Thespian Festival, LLC. and its Organizers to provide routine first aid, supervise the self-administration of over-the-counter and prescription medications and to seek medical assistance and/or treatment on behalf of the Delegate in the event that an illness or injury requiring such medical assistance and/or treatment occurs while the Delegate is attending or participating in the (Washington Thespian 2023-2024 Events). In the event that reasonable attempts to contact the individuals listed above are unsuccessful, the undersigned hereby authorizes and consents to (1) the administration of any treatment deemed necessary by the physician listed below or, if unavailable, such other licensed physician or other healthcare provider as may be available and (2) the transfer of the Delegate to the nearest hospital or other medical facility for emergency medical evaluation, care and treatment. The indemnification in Section I below shall expressly cover any claims related to the actions by the Washington State Thespians and its Organizers in (1) providing such routine first aid or supervision and (2) seeking such medical evaluation, care and treatment, and in providing any information reasonably requested by such emergency medical providers for purposes of providing or billing for services.

SIGNATURE OF PARENT/GUARDIAN OR DELEGATE OVER 18 YEARS OF AGE	**DATE**

I CONSENT TO A BACKGROUND CHECK (NON-STUDENTS)

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.

Failure to provide consent will result in the denial of or termination of my participation in any program involving children.

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.

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.

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.

SIGNATURE	**DATE**

FAMILY PHYSICIAN		☐ CHECK IF NONE
NAME		
PHYSICIAN PHONE NUMBER (10-digit)		
STREET ADDRESS		
CITY	STATE	ZIP CODE

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 #

I. RELEASE & INDEMNIFICATION

The undersigned hereby releases and agrees to indemnify, save and hold harmless International Thespian Festival, LLC., 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 International Thespian Festival, LLC.. 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 Washington State Thespians 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 Washington State Thespians 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. INTELLECTUAL PROPERTY RELEASE

The undersigned hereby assigns to the Educational Theatre Association all copyrights and other intellectual property rights in artwork, text, music, software, video, choreography and other types of work ("Works") created by the undersigned specifically for the undersigned's participation in the events or activities of the Organizers. The undersigned waives all rights in such Works under the Visual Artists Rights Act of 1990 and agrees to sign all further documents or instruments necessary to vest in the Educational Theatre Association all rights, title and interest in the aforementioned Works and intellectual property. The intellectual property rights hereby assigned to the Educational Theatre Association and waived by the undersigned do not include rights of the undersigned in works that pre-exist the undersigned's participation in the events or activities of the Organizers.

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 Washington State Thespians 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 Washington State Thespians 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

Washington State Thespians 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 have read, understand and agree to be bound by the above provisions, as evidenced by their signatures below:

SIGNATURE OF PARENT/GUARDIAN	DATE	SIGNATURE OF DELEGATE	DATE