

Adam Swartz Puppets: Summer Camp Registration & Release Form 2020

Circle week(s):

Camp Bill, August 3-7
Camp Bill, August 10-14

Art & Acting with Puppets, August 3-7
Puppet Camp, the Musical, August 10-14

Play Music: Barnyard, August 3-7
Play Music: Rainforest, August 10-14

Camper Name: _____ Age: _____ Grade in 2020-21 school year: _____

Parent/Guardian Name(s): _____ / _____

Preferred Phone: _____ Alternate Phone: _____

Preferred Email(s): _____

Camper Mailing Address:

Circle Camper T-Shirt Size:

Youth Small

Youth Medium

Youth Large/Adult Small

Adult Medium

Adult Large

Adult Extra Large

Are you interested in After-Camp Activities? _____

During camp, we will take photographs for a slideshow to be shown in camp only. We also may create video projects during camp. These photos and videos may also be used by Adam Swartz Puppets for printed or online promotional material.

Campers will never be identified by full name in photos or videos. Please circle your preferences:

I give Adam Swartz Puppets my permission to photograph my child for the camp slideshow.

YES or NO

I give Adam Swartz Puppets my permission to use these photographs for other materials.

YES or NO

I give Adam Swartz Puppets my permission to use camp videos for other materials.

YES or NO

I permit my child, _____ (first and last name) to participate in summer camp on the above dates. I also authorize any medical treatment in case of an emergency, and agree that I am responsible for the cost of such treatment. I agree to release, hold harmless and indemnify Adam Swartz Puppets and its agents, representatives and employees, from all claims, damages, or other liabilities for injuries to my son/daughter which are not the result of gross negligence, intentional neglect, or willful or wanton conduct by said agents, representatives, or employees.

List anyone else with permission to pick up your child:

List any medical or physical conditions, including allergies, teachers should be aware of:

Medication: _____ Dosage: _____

Prescribing/treating physician name: _____ Phone: _____

Other special
needs/comments: _____

Parent/Guardian Signature: _____ Date: _____