

**For Staff Use Only**

Audition #: \_\_\_\_\_

<u>Necessary Forms Checklist</u>	<u>Included</u>
Performer Registration Information:	_____
Medical Release Form:	_____
Signed Contract:	_____
Calendar noting conflicts:	_____



## High Voltage 2011-2012 Performer Registration Information

Complete this form and bring it to auditions:

Name of Participant: \_\_\_\_\_

Date of Birth \_\_\_\_\_<sup>first</sup> \_\_\_\_\_<sup>last</sup> Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Sex \_\_\_\_ male \_\_\_\_ female

Song Selections: \_\_\_\_\_ Vocal Range (if known): \_\_\_\_\_

If you are chosen as a member of High Voltage, are you able to attend the HV Camp Rehearsals July 25 – 27? \_\_\_\_ Yes \_\_\_\_ No

Please review the HV Calendar and advise of any conflicts to scheduled rehearsals / performances: \_\_\_\_\_

Please be sure to review the High Voltage Commitment Agreement in this registration packet (and on the HV website), particularly if you have conflicts or special requirements. If you have questions, please ask – [danielle@eembc.org](mailto:danielle@eembc.org)

Address: \_\_\_\_\_  
number and street city zip

Home Phone: \_\_\_\_\_ Birthday: \_\_\_\_\_

Performer's Cell: \_\_\_\_\_ Performer's E-Mail: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian #1 (Primary Contact): First: \_\_\_\_\_ Last: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Employer (optional): \_\_\_\_\_

Parent/Guardian #2 (Secondary Contact): First: \_\_\_\_\_ Last: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Employer (optional): \_\_\_\_\_

**It is important to list all e-mail addresses as they will be used for all High Voltage communications.**

Participant: \_\_\_\_\_  
Signature Parent/Guardian: \_\_\_\_\_  
Signature



# Authorization to Consent to Medical Treatment

Complete this form and bring it to auditions:

I/We, the undersigned, do hereby authorize representatives of El Dorado Musical Theatre (such representatives to be employees, directors, auxiliary members or identified volunteers) to serve as agents for the undersigned to consent to any x-ray exam, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by and is to be rendered under the general or specific supervision of any physician or surgeon licensed under the provisions of the Medicine Practice Act on the medical staff of any hospital licensed by the State of California whether such diagnosis or treatment is rendered at the office of said physician or at said hospital or some other site.

It is understood that this authorization is being given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of the aforesaid agent to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.

I (We) also understand and agree that EDMT will not be held responsible for injuries which occur to self/child while attending or participating in any EDMT function.

This authorization shall remain valid until revoked by parent or guardian.

Family Last Name: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_  
first last

Insurance Company: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Policy or Group Number: \_\_\_\_\_

Participant #1 \_\_\_\_\_ Date of Birth \_\_\_\_\_ Member ID No. \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Participant #2 \_\_\_\_\_ Date of Birth \_\_\_\_\_ Member ID No. \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Participant #3 \_\_\_\_\_ Date of Birth \_\_\_\_\_ Member ID No. \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Participant #4 \_\_\_\_\_ Date of Birth \_\_\_\_\_ Member ID No. \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Do any of the participants have any known medical conditions or allergies? (If yes, please describe): \_\_\_\_\_

In case of emergency, I would like EDMT to call the following people and phone numbers in the following order:

1st number: \_\_\_\_\_ Ask For: \_\_\_\_\_ Relationship: \_\_\_\_\_

2nd number: \_\_\_\_\_ Ask For: \_\_\_\_\_ Relationship: \_\_\_\_\_

3rd number: \_\_\_\_\_ Ask For: \_\_\_\_\_ Relationship: \_\_\_\_\_

Once a designated emergency contact has been contacted, EDMT need not call any additional numbers. If no contact is made after all numbers have been called, EDMT may leave a message at any of the above numbers, if possible.

I have read, understand, and agree to the El Dorado Musical Theater authorization to Consent to Medical Treatment.

Primary Parent and/or Guardian (please print): \_\_\_\_\_

Parent and/or Guardian Signature: \_\_\_\_\_



## High Voltage 2011-2012 Credit Card Authorization Form

*If you selected to be in High Voltage, complete this form and bring it to the Parent Meeting:*

Monthly Participation Fee: \$99.00 per performer

Name of Performer(s) \_\_\_\_\_

**Name on Card:** \_\_\_\_\_ Credit Card Type: \_\_\_ Visa \_\_\_ Mastercard (*check one*)

Credit Card #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_ 3 Digit Code: \_\_\_\_\_

Billing Address \_\_\_\_\_  
\_\_\_\_\_

I authorize El Dorado Musical Theatre to charge this account once each month for the 12-month period commencing July 1, 2011 and ending June 30, 2012.

Signature \_\_\_\_\_ Date: \_\_\_\_\_