



Consent and Acceptance Form – 2015/2016

The **WASHINGTON STATE THESPIANS**, an affiliate of the Educational Theatre Association, requires that this form be completed for each delegate (students and adults) attending the **WA STATE THESPIAN 2015-2016 CHAPTER EVENTS including: In-service training, college auditions, local IE festivals, State Thespian Festival at Garfield, Roosevelt, Lewis and Clark, Mountlake Terrace, Olympia High Schools and Central Washington University.** If a Delegate is a minor (under 18), a parent or legal guardian must complete this form. The health center will not treat adults. Medications will be charged to the delegate. If you substitute a delegate, you must supply a new completed health form. Type or print legibly. Enter name exactly as it appears on registration form. Return prior to attendance at each specified event.

Delegate information

_____ Delegate's first name (as on registration form)		_____ Last name	_____ Gender
_____ Thespian Troupe no.	_____ Name of School	_____ Delegate's birthdate (____)_____	
_____ Home address (street, city, state, zip)		_____ Phone number (____)_____	
_____ Name of parent/guardian/next of kin		_____ Phone number	
_____ Name of troupe director or chaperone attending State Thespian Sponsored Event(s)			

I. RELEASE

The undersigned hereby releases and agrees to indemnify, save and hold harmless the **WASHINGTON STATE THESPIANS**, the International Thespian Society, the Educational Theatre Association, the Sponsoring school, 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 the State Thespian Sponsored Event. 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 the State Thespian Sponsored Event, 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 this form.

II. RULES AND REGULATIONS

The undersigned agrees that the Delegate shall abide by the State Thespian Sponsored Event's security rules and regulations (as described in detail at least at www.washingtonthespians.org). The undersigned understands that, if the Delegate violates any of the State Thespian Sponsored Event 's security rules and regulations, the Delegate may be returned home, and the undersigned (or other parents and/or legal guardians) may be financially responsible for all necessary costs incurred while sending Delegate home. The undersigned also understands that the State Thespian Sponsored Event registration fees cannot be refunded after said event.



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III. 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 the 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 Directors 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 nearest medical facility 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 nearest medical facility. 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 nearest medical facility 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.

The Delegate or the Delegate's parent and/or legal guardian has read, understands, and agrees to be bound by the above provisions, as evidenced by their signature below:

Signature of Delegate's parent and/or legal guardian

Date

Signature of Delegate

Date