



Registration/Health Form

one form per cast member - please print clearly

Online Form
www.ctexperience.com

With Adobe Acrobat Reader, you may type your information directly onto this form. Be sure to complete all boxes. You may then save this document and email it to us at cte@ctexperience.com, or you may print this form and fax it to us at (818) 591-7049 or bring it with you to the first rehearsal - registration event.

Show Information

Show Title:	First Rehearsal - Registration Date:
Community: <input type="checkbox"/> Claremont <input type="checkbox"/> Conejo Valley <input type="checkbox"/> Glendale/Pasadena <input type="checkbox"/> Orange County <input type="checkbox"/>	

Cast Member Information

First Name	Middle Name	Last Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Address	City	State	Zip Code	
Home Phone	School	School District		
Age	Grade	Birthdate	Primary Email Address (Parent's):	

Mother's (Parent/Guardian) Information

First Name	Last Name	<input type="checkbox"/> Parent <input type="checkbox"/> Guardian
Work Phone	Emergency Number	___ pgr ___ cell ___ other

Father's (Parent/Guardian) Information

First Name	Last Name	<input type="checkbox"/> Parent <input type="checkbox"/> Guardian
Work Phone	Emergency Number	___ pgr ___ cell ___ other

Emergency Contact Information

First Name	Last Name	<input type="checkbox"/> Relative <input type="checkbox"/> Friend
Work Phone	Emergency Number	___ pgr ___ cell ___ other

Emergency and Medical Information

Child's Doctor:	Phone:	Hospital:
Allergic reactions to: <input type="checkbox"/> Bee Stings <input type="checkbox"/> Drugs <input type="checkbox"/> Foods <input type="checkbox"/> Other _____		Any physical restrictions?
Chronic or recurring medical conditions:		
Insurance Carrier:	Policy Number:	
Address:	Phone:	
Medicine currently being taken:	Dosage/interval of administration:	

In Case of Emergency, I hereby give my permission to the hospital, physician or dentist to provide emergency treatment for my child listed on this form: this includes the administration of injections, anesthesia, and/or emergency surgery as deemed necessary by my child's condition. I understand that every reasonable attempt will be made to contact me prior to such treatment.

Signature: _____ Relationship: _____ Date: _____

Payment Information

(for office use only)

Payment may be made by Check (please make checks payable to Children's Theatre Experience), Money Order, Visa or MasterCard. Return Registration/Health Form and payment to CTE, 18034 Ventura Blvd., #203, Encino, California 91316-3516.

Payment Amount: \$ _____
<input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> Money Order <input type="checkbox"/> PP _____
<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard Card No. _____ Expiration Date _____

I hereby acknowledge that the registration fee is non-refundable and under no circumstances will it be refunded.

I understand that CTE retains the right to use photographs/video images of cast members taken during this production for publicity and advertising purposes.

Signature: _____ Relationship: _____ Date: _____