



Registration Form

Please Make Copies if Needed!

Please Print or Type

Mail completed form with \$30.00 Registration Fee to:

LOUISIANA THEATRE FESTIVAL

809 Kirby Street; Suite 313

Lake Charles, LA 70601

337.377.2571

809 Kirby Street; Suite 313
Lake Charles, LA 70601
337.377.2571
www.LTF.cc

To pay your registration fee online, click the secure Pay Now button on the homepage. Next, complete the Registration Form and Health Form. Mail both forms immediately to confirm your registration.

Date of Registration: _____

Name of Student: _____

LAST

FIRST

Home Phone: (____) _____ - _____

Parent Cell: (____) _____ - _____

Parent Cell: (____) _____ - _____

Student Cell: (____) _____ - _____

Parent's Name: _____

Home Mailing Address _____

City: _____ State: _____ Zip: _____

Parent E-Mail Address: _____

Student E-Mail Address: _____

Student's Age: _____ Birthday: ____/____/____

School Attending: _____

Grade: _____

The undersigned hereby releases and agrees to hold harmless the Louisiana Theatre Festival and all respective agents, employees and representative of the aforementioned entities from any and all claims, demands, actions and causes of action as a result of the delegate listed above participating in the Louisiana Theatre Festival, Central School of the Arts & Humanities, Lake Charles, Louisiana. The undersigned further agrees to be responsible for him/herself while traveling to and from said Festival including any expenses incurred by the delegate, caused by the delegate and / or any personal injuries which may occur to the delegate. The undersigned agrees to abide by the conference's security rules and regulations with the understanding that should any problems occur with the delegate during the Festival, the delegate will be returned home and parents, guardian or next of kin of the delegate will be financially responsible for all necessary costs incurred. The undersigned also realizes that festival registration fees are non-refundable. The undersigned further understands that should a major medical problem arise, he/she will be notified by telephone.

The undersigned hereby grants to the Louisiana Theatre Festival permission to make photographs of the delegate at said festival for use in coverage of the event, advertising, and for any lawful purpose without compensation to the delegate. The undersigned certifies that he/she has read and fully understands this authorization.

Parent Signature

Student Signature

____/____/____
Date

NEXT PAGE: COMPLETE THE HEALTH FORM



Louisiana Theatre Festival
809 Kirby Street, Suite 313
Lake Charles, LA 70601
337.377.2571
mail@ltf.cc
www.LTF.cc

...gotta' be there!

HEALTH FORM

The Health Form, Registration Form & Fess must be complete before a child enrolls.

The undersigned hereby releases and agrees to hold harmless THE LOUISIANA THEATRE FESTIVAL (LTF) and all respective agents, employees and representatives of the aforementioned entities from any and all claims, demands, actions and causes of action which the undersigned may have as a result of the person listed below participating with THE LOUISIANA THEATRE FESTIVAL. The undersigned further agrees to be responsible for him/herself while traveling to and from LTF including any expenses incurred by the student, caused by the student and/or any personal injuries which may occur to the student. The undersigned also agrees to abide by all LTF's policies, rules and regulations with the understanding that should any problems occur with the student during the duration of above stated activity, the student will be returned home and parents, guardian, or next of kin of the student will be financially responsible for all necessary costs incurred. The undersigned also realizes that fees related to this activity cannot be refunded. The undersigned further understands that should a major medical problem arise, s/he will be notified by telephone. In the event that s/he cannot be reached, s/he hereby gives consent to such medical treatment as deemed necessary including x-ray examination and anesthesia to be rendered by a licensed physician or physicians. The undersigned certifies that s/he has read and fully understands this authorization.

Please Print or Type

Student's first name: _____ Last Name: _____

Student's Birthday: _____ Student's age: _____ T-Shirt Size: _____

Home Address: _____ City: _____ Zip: _____

Name of Parent/ Guardian/ Next of Kin: _____

Parent Home Phone: _____ Parent Work Phone: _____ Parent Cell: _____

Allergic reactions to _____

Medications presently being taken: _____

Any past illnesses or other information that would be useful in the event medical treatment necessary: _____

Payment will be made by: Parents, Guardian, Student or Insurance Company: _____

FAMILY PHYSICIAN: _____ Phone Number: _____
Address: _____ City: _____ State: _____ Zip: _____

HEALTH INSURANCE COMPANY: _____
Policy Number: _____
Address: _____ City: _____ State: _____ Zip: _____

PRINT NAME/ Parent/ Guardian or Next of kin

SIGNATURE/ Parent/ Guardian or next of kin _____ Date _____