



OKLAHOMA THESPIANSSM

AN EDUCATIONAL THEATRE ASSOCIATION AFFILIATE

Consent and Acceptance Form

The OKLAHOMA THESPIANS, an affiliate of the Educational Theatre Association, requires that this form be completed for each delegate (students and adults) attending the **OKLAHOMA THESPIAN FESTIVAL** at the **Tulsa Community College – Southeast Campus**. 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 by **December 1 with all other registration materials and payment**.

Delegate information

Delegate's first name (as on registration form) Last name Gender

Thespians 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 **the OKLAHOMA THESPIAN FESTIVAL**

I. RELEASE

The undersigned hereby releases and agrees to indemnify, save and hold harmless the **OKLAHOMA THESPIAN FESTIVAL, OKLAHOMA THESPIANS**, the International Thespians Society, the Educational Theatre Association, the **Tulsa Community College**, 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 **OKLAHOMA THESPIAN FESTIVAL**. 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 **OKLAHOMA THESPIAN 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 authorizes the Delegate to be released to the Troupe Director or Chaperone listed on this form.



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II. RULES AND REGULATIONS

The undersigned agrees that the Delegate shall abide by the **OKLAHOMA THESPIAN FESTIVAL'S** security rules and regulations (as described in the Code of Conduct). The undersigned understands that, if the Delegate violates any of the **OKLAHOMA THESPIAN FESTIVAL'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 **OKLAHOMA THESPIAN FESTIVAL** registration fees cannot be refunded after **February 1**.

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 **Hillcrest Hospital - South** 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 **Hillcrest Hospital - South**. 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 **Hillcrest Hospital - South** 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