MST&DA Performance Theatre Registration

Family Name _____ Today's date _____

Participant Name:_____Cell: _____ Email: _____
Participant Name:_____Cell: _____ Email: _____
Participant Name:_____Cell: _____ Email: _____
Participant Name:_____Cell: _____ Email: _____

Parent 1 Name:_____ Cell:: _____ Email: _____
Parent 2 Name:_____ Cell:: _____ Email: _____

Children's Theatre is offered on Tuesday or Wednesday in the Fall. Tuition is $375 for Fall & $425 for Spring. Full year is $750 when paid in FULL by beginning of Fall semester.
Teen Theatre is offered on Wednesday with one additional rehearsal day TBA. Tuition is $425 for Fall & $425 for Spring. Full year is $785 when paid in FULL by beginning of Fall semester.
Adult Musical Theatre Studio is on Saturday from 10am-4pm with one additional day TBA. Production fee is $475.
*Please note the class and day for each participant below. **If available both days for children's theatre**, please put "B" for both under the "Day" option. You will then be notified of your day assignment based on class size.

Participant	**Class**	**Day**	**Time**	**Amount Due**
_____	_____	_____	_____	$ _____
_____	_____	_____	_____	$ _____
_____	_____	_____	_____	$ _____
_____	_____	_____	_____	$ _____
			Sub-Total	$_____

Waiver & Release
I understand that Main Street Theatre & Dance Alliance shares my concern about my safety and that of my child. I understand that MST&DA and its landlord, RIOC, do not accept responsibility for injuries, damages or loss, which my child or I may suffer while participating in its programs. Accordingly, I agree to assume the full risk of any physical injuries, damages or loss, regardless of severity, which my child or I may sustain as a result of participating in any and all activities connected with or associated with any MST&DA programs.
Permission to Secure Treatment
In the event of an emergency, I authorize MST&DA to render basic first aid and to secure from any licensed hospital, physician, and/or medical personnel any treatment deemed necessary for my or my child's immediate care, and agree that I will be responsible for payment of any and all medical services required.

P**ediatrician/Physician:** NAME _____ PHONE #_____

My signature affirms my acceptance of the Waiver & Release & Permission to Treat:

Name_____ Relationship_____Signature_____Date_____

I give permission to use pictures of myself and/or my child for display and marketing purposes only.
_____(initial)