

# Aboriginal Arts Training and Mentorship Program

## Spring 2011

PROGRAM DIRECTOR: COLUMPA C. BOBB

Name of Student: \_\_\_\_\_  Male  Female

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Aboriginal/Métis heritage:  Yes  No

CLASS LEVELS	CLASS DAY & TIME		AGE	
NEW STUDENTS	Wednesdays Intro to Theatre	4:30 - 6:30 pm	13 to 19 years	<input type="checkbox"/>
RETURNING STUDENTS	Thursdays Sketch Comedy	4:30 - 6:30 pm	13 to 19 years	<input type="checkbox"/>
RETURNING STUDENTS	Fridays Film	4:30 - 6:30 pm	13 to 15 years	<input type="checkbox"/>
	MyLife Project – Part 2	4:30 - 6:30 pm	13 to 19 years	<input type="checkbox"/>
	 Musical Theatre (for new & returning students)	6:45 - 8:45 pm	13 to 19 years	<input type="checkbox"/>

In the space below let us know how you heard about the program. This helps us with recruitment planning for next year!

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Classes begin  
APRIL 6<sup>th</sup>  
Register Now!**

Home Address: \_\_\_\_\_ City: \_\_\_\_\_

Phone (s): \_\_\_\_\_ Postal Code: \_\_\_\_\_

E-mail: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

School Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

**Name of Parent/Guardian who will actively support and encourage the student's ongoing participation in the program:** \_\_\_\_\_

Home Phone(s): \_\_\_\_\_ Work Phone: \_\_\_\_\_

Is there any medical or behavioural information the instructor should be aware of to prepare for the class?  
(ADD, medications, allergies, etc...) \_\_\_\_\_

**Secondary Contact in case of emergency:** \_\_\_\_\_

Relation: \_\_\_\_\_ Phone(s): \_\_\_\_\_

TO CONTACT PROGRAM STAFF:

Phone: 947-0394 ext. 246

Fax: 943-4129

E-mail: [aboriginalarts@mtyp.ca](mailto:aboriginalarts@mtyp.ca)

Ask about free transportation to and from class!

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# 2010-2011 CONSENT FORM

for PARENT/GUARDIAN of student

I consent for \_\_\_\_\_ (first and last name of student)  
to participate in the Aboriginal Arts Training & Mentorship Program. I understand that this  
program offers free Theatre Arts Training classes to my child and will ensure that my  
child attends regularly.

**In the case of illness or some other reason my child is unable to attend his or her  
weekly class, I will contact the Program Staff as soon as possible to inform them  
that my child will be missing class.**

I understand that my support and encouragement of my child's participation in  
the Program is important.

I also consent to allow my child to appear in photos or on television for publicity  
purposes relating to the Aboriginal Arts Training Program.

**PARENT OR ADULT CAREGIVER:**

Name (Please print): \_\_\_\_\_

Signature: \_\_\_\_\_