

# ACTs Day Camp Registration Form

## Hope Evangelical Free Church

CHILD'S LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ HOME PHONE (\_\_\_\_) \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP CODE \_\_\_\_\_

AGE \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ GIRL \_\_\_\_\_ BOY \_\_\_\_\_ GRADE IN FALL 2016 \_\_\_\_\_ SCHOOL \_\_\_\_\_

1. Parent/Guardian \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_ Email Address \_\_\_\_\_

2. Parent/Guardian \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_ Email Address \_\_\_\_\_

### EMERGENCY CONTACTS/PERSONS AUTHORIZED TO PICK UP CHILD

In case of emergency, if the parent/guardian cannot be reached, we will contact the persons listed below. NO PERSON besides the parent/guardian or those listed below will be authorized to pick up your child.

NAME \_\_\_\_\_ RELATION TO CHILD \_\_\_\_\_ PHONE # \_\_\_\_\_

\_\_\_\_\_

NAME \_\_\_\_\_ RELATION TO CHILD \_\_\_\_\_ PHONE # \_\_\_\_\_

\_\_\_\_\_

### MEDICAL AND ALLERGY INFORMATION

MEDICAL INSURANCE CO. \_\_\_\_\_ POLICY/SUBSCRIBER # \_\_\_\_\_

Allergies: No allergies \_\_\_\_\_ Hay Fever \_\_\_\_\_ Insect Stings \_\_\_\_\_ Food \_\_\_\_\_ Other \_\_\_\_\_

Does your child require any special accommodations (I.e: IEP, Behavior Plan)? \_\_\_\_\_

### PARENT/GUARDIAN AGREEMENT and RELEASE (please initial):

\_\_\_\_ I give permission for my child to participate in all ACTs Day Camp activities, field trips. I have no knowledge of any physical impairment that would prevent my child from participating in the program.

\_\_\_\_ I hereby authorize Hope Evangelical Free Church and the ACTs Day Camp program to use any pictures and videos taken of my child for any purpose including but not limited to future promotional use.

\_\_\_\_ I hereby release and forever discharge and agree to indemnify and hold harmless Hope Evangelical Free Church and its employees, officers, directors, members, agents, attorneys, predecessors, successors, assigns, affiliates, representatives, and volunteers of and from any and all injuries, actions, suits, proceedings, claims, demands, assessments, judgments, damages, deficiencies, liens, penalties, fines, costs and expenses, including reasonable attorneys' fees, resulting from, arising out of or based upon the ACTs Day Camp program.

\_\_\_\_ I authorize medical treatment to be given to my child in the event I cannot be reached.

\_\_\_\_ I agree that my child shall adhere to all rules and regulations of the ACTs Day Camp program. If, at the Director's discretion, it is decided that the child is unable to continue respectfully in our program, I agree that no refund will be given.

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_