



**Acts Day Camp Program**  
Hope Evangelical Free Church  
415-661-9718 ([www.hopeefc.com](http://www.hopeefc.com))

**Date:** June 1, 2015 to June 12, 2015 (2 weeks only)

**Age Group:** Children entering grades 1 to 6 (ages 6 – 12) in Fall 2015

**Location:** 3601 Noriega Street, San Francisco - Corner of 43rd Avenue

**Program Cost:** \$260

**Program Hours:** 9AM to 4:00PM

**Extended care cost for additional** \$50 for entire week

(Extended care hours: 8:00AM – 9:00AM and 4:00PM – 6:00PM)

**Deadlines and payment:**

Registration deadline is based on when each grade level capacity is filled. Spaces fill up quickly. (Registration may be closed once maximum capacity for an age group is reached.)

Payments can be made by check.

Please make checks payable to: Hope Evangelical Free Church.

**Cancellation / Refund Policy:**

You will receive the total program fees minus a \$25 processing fee if you request a refund prior to May 1, 2015. If you need to cancel your registration after May 1 and before May 15, you will receive a refund of 75% of the program fee.

**Send your application form with payment to:**

Hope Evangelical Free Church  
Attn: Acts Day Camp Program  
3601 Noriega Street  
San Francisco, CA 94122

# 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 2015 \_\_\_\_\_ 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 (Ie: 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 \_\_\_\_\_