CVMS Art Camp!

REGISTRATION FORM

June 5-7th Wed.- Fri. 9:00-12:00

Student's name _____ age _____ grade _____

Mother, Father / Guardian's Name _____

Home Phone: _____ Cell :_____ Work:_____

Home Address: _____

City/State/Zip: _____

Work Phone: _____ Cell Phone: _____ Email:_____

Who will be picking up your child promptly at 12:00 noon? (List 2 alternative people if needed)

_____

Your payment reserves your spot **$60** **Make checks out to:* **CVMS MEMO: Art Camp**

CONTACT INFORMATION AND RELEASE FOR MEDICAL TREATMENT IN CASE OF EMERGENCY

When Parent(s)/Guardian(s) cannot be reached, please call _____

Relationship to student: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

RELEASE FOR EMERGENCY MEDICAL TREATMENT

As custodial parent or guardian of *(child's full name)* _____

I do hereby authorize the teachers and leaders to take my child to any hospital emergency room for treatment, without first obtaining my consent in the event my child is sick, hurt, or in need of medical attention and it is impossible or impractical for a representative of CVMS Art summer camp to get in touch with me prior to obtaining medical attention for my child. I do further release and absolve the summer camp leadership, investors, teachers, and staff from any liability as a result of obtaining such medical treatment for my child.
Further, I authorize the doctor or doctors, nurses, hospital or emergency room of any hospital to render the treatment necessary for the illness, sickness, or injury of my child who is brought to such institution for treatment.

Custodial Parent/Guardian (printed name): _____

Signature: _____ Date: _____

RECEIVED: _____ Cash or Check Number _____