

METHODIST TEMPLE DAY CAMP
Summer 2009

NAME / NAMES _____
AGE _____ GRADE(2008-2009) _____
ADDRESS _____ ZIP CODE _____
TELEPHONE NUMBER _____
BIRTH DATE _____ SCHOOL _____
FATHER'S NAME _____ MOTHER'S NAME _____
EMPLOYER _____ EMPLOYER _____
WORK NUMBER _____ WORK NUMBER _____
CELL NUMBER _____ CELL NUMBER _____

NAMES OF PEOPLE AUTHORIZED TO PICK UP MY CHILD

1. _____ PHONE _____
2. _____ PHONE _____

NAMES OF PEOPLE NOT AUTHORIZED TO PICK UP MY CHILD

1. _____
2. _____

PLEASE LIST ANY MEDICAL CONDITIONS, DISABILITIES OR
BEHAVIOR PROBLEMS WE SHOULD KNOW ABOUT IN ORDER TO
BETTER UNDERSTAND YOUR CHILD. _____

REGISTRATION DEADLINE – April 15 2009

REGISTRATION _\$150.00 per child
DATE PAID _____ CHECK # _____

Please check days your child will attend
5 day _____ 4 day _____

PERMISSION FORM

MY CHILD _____ HAS MY PERMISSION TO ATTEND METHODIST TEMPLE DAY CAMP AND TO ATTEND ALL FIELD TRIPS AND TO TRAVEL BY SCHOOL BUS.

MY CHILD HAS MY PERMISSION TO WATCH PG MOVIES. _____

MY CHILD HAS MY PERMISSION TO BE PHOTOGRAPHED BY THE TV STATIONS OR THE NEWSPAPER FOR PUBLICITY PURPOSES. _____

THE UNDERSIGNED CERTIFY THEY ARE THE PARENTS OF _____ BORN _____. THE UNDERSIGNED RECOGNIZES THAT THERE MAY BE CIRCUMSTANCES IN WHICH THE UNDERSIGNED MAY NOT BE ABLE TO GIVE CONSENT FOR MEDICAL TREATMENT OR HOSPITAL CARE FOR SAID CHILD. BY THIS DOCUMENT, THE UNDERSIGNED HEREBY AUTHORIZES A DOCTOR OR DOCTORS SELECTED BY STAFF PERSON IN CHARGE OF METHODIST TEMPLE DAY CAMP, OR DOCTORS ATTACHED TO ANY EMERGENCY ROOM OF A HOSPITAL, TO PERFORM SUCH MEDICAL SERVICES OR PROCEEDURES AS ARE CONSIDERED NECESSARY IN CONNECTION WITH AN INJURY OR ILLNESS A CHILD MAY HAVE, WHEREVER HE OR SHE IS LOCATED, AND IF THE UNDERSIGNED ARE NOT AVAILABLE TO CONSENT AT SAID TIME.

HOSPITAL PREFERENCE _____

HEALTH INSURER _____ POLICY NUMBER _____

CHILD'S DOCTOR _____ PHONE NUMBER _____

CHILD'S DENTIST _____ PHONE NUMBER _____

CHILD'S MEDICATIONS _____

PARENT SIGNATURE _____ DATE _____

