

# EARLY ARTS ART CAMP SUMMER 2010

FEE \_\_\_\_\_

CK # \_\_\_\_\_

## PLEASE PRINT

Child's Name \_\_\_\_\_  
Child's Birthday \_\_\_\_\_ Age \_\_\_\_\_ Gender: M / F  
Parent's Names \_\_\_\_\_  
Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
EMAIL \_\_\_\_\_

Cost per Session: \$125

Hours: 9-1

For Rising 5K students only

Please Circle Sessions you wish to attend:

SESSION	1	June 14 -17	All Girls
	2	July 12 - 15	Girls and Boys

## IMPORTANT CONTACT NUMBERS

Mother's Cell Phone \_\_\_\_\_ Father's Cell Phone \_\_\_\_\_  
Mother's Work Phone \_\_\_\_\_ Father's Work Phone \_\_\_\_\_  
Other Phone numbers \_\_\_\_\_  
Child's Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

## EMERGENCY CONTACTS

Persons to contact if parents cannot be reached in event of illness or injury:

1. Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_  
2. Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

## Authorization to Release Child

Early Arts Preschool personnel are authorized by my signature below to release my child,  
\_\_\_\_\_ to the following persons:

Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

**MEDICAL \ ALLERGIC CONDITIONS**

Child's Medical \ Allergic Condition: \_\_\_\_\_

Child's Physical Reaction \ Response: \_\_\_\_\_

Treatment for Condition: \_\_\_\_\_

**Medical Authorization**

Early Arts Preschool personnel are authorized by my signature below to seek medical assistance/treatment if I am unable to be contacted in case of an emergency involving my child, \_\_\_\_\_ including transporting my child to Children's Hospital either by ambulance/emergency vehicle or personal vehicle.

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

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**DON'T FORGET YOUR BLUE FORM**