

Preschool Kidz Kamp

Christ Lutheran Learning Center
(2010)

Please indicate which session(s) you are registering for:

	Session 1: Monday – Thursday, June 14-17, 9:00 a.m. to 1:00 p.m.	\$70.00
	Session 2: Monday – Thursday, July 12-15, 9:00 a.m. to 1:00 p.m.	\$70.00

Child's Name _____ Date of Birth _____

Age as of March 1, 2010 _____ Home Telephone _____

Address _____
(street) (city) (zip code)

Mother or guardian _____ Cell Phone _____

Father and Guardian _____ Cell Phone _____

E-mail _____

Name and Telephone number of **other** persons authorized to pick up child:

(Name)

(Phone)

(Name)

(Phone)

(Under no circumstances will your child be released to anyone not known to the school without authorization from parents or guardian.)

Persons to be called in case of emergency:

Name _____ Relationship to Child _____

Address _____ Phone _____

Name _____ Relationship to Child _____

Address _____ Phone _____

Authorization for emergency medical attention

In the event I cannot be reached to make arrangements for emergency medical attention at the time of the illness or accident, I hereby authorize Christ Lutheran Learning Center (Preschool Kidz Kamp) to take my child,

_____, to Dr. _____

Address of physician _____ Phone _____

or to _____ Clinic or Hospital, and I give consent for any and all necessary treatment for my child when the child is in this individual's care. In the event of a serious emergency, Georgetown Hospital Emergency will be used.

Signed _____ Date _____

Permission to participate in Preschool Kidz Kamp activities

I hereby grant permission for my child to use all of the play equipment and to participate in all of the activities of the Kidz Kamp.

I hereby grant permission for my child to be included in pictures connected with the Kidz Kamp.

As parent or guardian, I assume all the risks and hazards of participation in the Preschool Kidz Kamp, and I waive all claims against Christ Lutheran Church or any directors, teachers, or helpers appointed by them.

Signed _____ Date: _____

Special problems or needs

My child has these special problems or needs: (include any allergy, existing illness, previous serious illness, hospitalizations during the past 12 months, and any medication prescribed for long-term, continuous use.)

Signed _____ Date: _____

	Amount Paid	Check #	Cash
Payment for Session 1			
Payment for Session 2			