



For Office Use
Pymt date _____
Reg fee: Amt _____ cash/check (ck# _____)
Tuition: Amt _____ cash/check (ck# _____)
Donation: _____

**RETURNING STUDENTS
ONLY
USE THIS FORM**

Summer Camp 2009

Name: _____ M F Age: _____
Parent Name: _____ '08-'09 Grade: _____
Birthday: _____

Summer Camp: \$125 per week *

(each week's fee is due 2 weeks prior to start of camp week)

Monday-Friday 9:00 a.m.—3:00 p.m.

- Week 1: July 6-10
- Week 2: July 13-17
- Week 3: July 20-24
- Week 4: July 27-31
- Week 5: August 3-7
- Week 6: August 10-14

Registration Fee (one-time; non-refundable)

\$20 per child; max \$50 per family
(due at time of registration)

Before Care: \$15 per week*

- 7:30 a.m. - 9:00 a.m.

After Care: \$20 per week*

- 3:00 p.m. - 5:30 p.m.

(before/after care fees are due with tuition payment)

***Costs are suggested minimums. As a non-profit organization we rely in part on donations from friends and community members. If you are able to give beyond the suggested minimum cost, it will be considered a tax-deductible donation.**

***We understand that there are times and circumstances that make it difficult to add extras into family budgets. Scholarships are available through a confidential process. Contact the Riverside Children's Arts Center at 904-389-1751 with further questions.**

Students must be picked up by 3:15 pm daily for summer camp. If you are not able to pick up your child by 3:15 pm each day, please arrange for your child to participate in our After Care program.

Parent/Guardian Permission

I, the undersigned, have legal custody of the student named above, a minor, and have given my consent for him/her to attend programs/events being organized by the Riverside Children's Arts Center. I understand that there are inherent risks involved in any program/event, and I hereby release the Riverside Children's Arts Center, Riverside Avenue Christian Church, its pastors, employees, agents, and volunteer workers from any and all liability for any injury, loss, or damage to person or property that may occur during the course of my child's involvement.

In the event that he/she is injured and requires the attention of a doctor, I consent to any reasonable medical treatment as deemed necessary by a licensed physician. In the event treatment is required from a physician and/or hospital personnel designated by the Riverside Children's Arts Center, I agree to hold such person free and harmless of any claims, demands, or suits for damages arising from the giving of such consent. I also acknowledge that we will be ultimately responsible for the cost of any medical care should the cost of that medical care not be reimbursed by the health insurance provider. I also agree to bring my child home at my own expense should they become ill or if deemed necessary by a staff member.

Parent/guardian signature: _____

Date: _____

Media Release

I understand representatives of the Riverside Children's Arts Center may be photographing or filming the Arts Center's classes, rehearsals, lessons, and/or performances. I also understand that art created by my child may be photographed or filmed, or may be displayed in an appropriate venue.

I give my permission for resulting photographs, which may include my child and/or his/her art, to be used for promotional purposes on television, or in newspapers, magazines, display or any other media deemed appropriate by the staff of the Riverside Children's Arts Center.

Student's name: _____

Parent/guardian signature: _____

Date: _____

NOTE: Please complete this portion ONLY if there are CHANGES since your child's last enrollment with us.

Contact Information

Address: _____

School: _____ Home Phone: _____

Mother's Name: _____

Phone: Home _____ Work _____ Cell _____

Email: _____

Father's Name: _____

Phone: Home _____ Work _____ Cell _____

Email: _____

Emergency Contact: _____

Phone: Home _____ Work _____ Cell _____

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Preferred Hospital: _____

Child lives with: Mother Father Both Other _____

Medical History

1. Does your child have allergies:
 pollens? medications? food? insect bites?
Please list: _____
2. Does your child suffer from, or has ever experienced, or is being treated currently for any of the following:
 asthma? physical handicap? heart trouble? diabetes?
 frequently upset stomach? epilepsy/seizure disorder?
4. Date of last tetanus shot: _____
5. Does your child wear:
 glasses? contact lenses? hearing aids?
6. Please list and explain any major illnesses/surgeries the child experienced during the last year:

7. Should this child's activities be restricted for any reason? Please explain:

If necessary, please describe in detail the nature and severity of any physical and/or psychological ailment, illness, propensity, weakness, limitation, handicap, disability, or condition to which your child is subject and of which the staff should be aware, and what, if any action or protection is required on account thereof. Submit this notification in the space below and attach additional pages if necessary. Include names of medications and dosages that must be taken.
