



CryOut! Summer Day Camp Registration

Child's Name _____ Sex _____

Age ___ Date of Birth _____ Last Completed Grade _____

School _____

Address _____ City _____ Zip _____

Home Phone _____ Child lives with: Mother Father Other:

Email Address (required) _____

Parent / Legal Guardian Name _____

Work Phone _____ Cell Phone _____

Parent / Legal Guardian Name _____

Work Phone _____ Cell Phone _____

REFUND POLICY

Day Camp deposits are non-refundable and non-transferable. Refunds for the remaining camp fees will be granted when a written request is received no later than two weeks prior to the start of each camp session.

Full refunds will be made for any session that is canceled by CryOut!.

___ I agree to the refund policy as stated above (Initials)

EMERGENCY CONTACTS

If parents cannot be reached, who can we call?

Name Phone # Relationship

1 _____

2 _____

Child's medical history/cautions, medical/special needs (medications, allergies, drugs, physical or mental disability, behavioral disorders, attention disorders, others):

OTHERS AUTHORIZED TO PICK-UP CHILD

List all persons (18 and older) including parent(s) authorized to pick up your child:

Name Address Phone # Relationship

1 _____

2 _____

3 _____

List all persons including parent(s) who are not authorized to pick up your child: (A court order must be on file in order to authorize the enforcement of this restriction.)

Name Address Phone # Relationship

1 _____

2 _____

INSURANCE

It is the responsibility of every individual, their parent or legal guardian to provide for their own accident and health coverage while participating in all CryOut! activities.

AUTHORIZATION

Participation: I give permission for my child to participate in all activities, field trips, swimming and to be transported as authorized by CryOut!.

Medical Treatment: I hereby give permission that my child may be given emergency treatment by a qualified staff member of the Recreation Division. I also give permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

In the event I cannot be contacted, I further consent to the medical, surgical and hospital care, treatment, and procedures to be performed for my child by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health.

WAIVER OF LIABILITY

To my knowledge my son/daughter is physically healthy and able to participate in the class for which he/she is registered. I/We, the parents/guardians of

“Being fully informed as to these risks and in consideration of my being allowed to participate in city sponsored activities and/or use of city facilities, I hereby assume all risk of injury, damage, and harm to myself arising from such activities or use. I also hereby individually and on behalf of my heirs, executors, and assigns release and hold harmless CryOut!, it's officials, employees and agents, and waive any right of recovery that I might have to bring a claim or a lawsuit against them for any personal injury, death, or other consequences occurring to me arising out of my voluntary participation in this activity.” I hereby give permission to CryOut! to use any photos taken during this activity, which might include me or my child (children), in publications promoting programs or activities with CryOut!

I have read and understand the above:

Signature of Parent / Legal Guardian _____ Date _____



Child's Name _____

Health Condition _____

Name of Medication(s) _____

Dosage or amount per administration _____

Time(s) of day to be given _____

Possible side effects of medication _____

Special instructions for handling medication/comments

I request and authorize that the above named child be reminded to self-medicate themselves in accordance with the instructions indicated, as there exists a valid health reason which makes the administration of the medication advisable during program hours or during the time the child is under the supervision of CryOut!.

Signature of Parent / Legal Guardian _____ **Date** _____

Note to parents: All medication must be in its original container and the label must include the child's name, name of medication, dosage, method of administration, and name of physician. Send only that day's dosage. Please do not leave medication in the possession of your child or in their lunch box.

Date Time Initials

Signature(s) that correspond to initial of person(s) giving medication:
