



SUMMER CAMP 2015

PLEASE PRINT

NAME OF CAMP: ALLIED HEALTH CAREER EXPLORATION

AGE GROUP: 6TH – 8TH GRADES

DATES OF CAMP: July 6 – July 9th

TIMES: 8:30 a.m. – 12:30 p.m.

COST: \$40, INCLUDES SNACKS AND CAMP T-SHIRT

PARTICIPANT T-SHIRT SIZE: YOUTH: S M L XL ADULT: S M L XL

DUE DATE: REGISTRATION FEE AND PERMISSION SLIPS DUE NO LATER THAN JUNE 1, 2015

PARTICIPANT NAME: _____ **AGE:** ___ M ___ F ___

PARENT/GUARDIAN NAME: _____

MAILING ADDRESS: _____

EMAIL ADDRESS: _____

CITY: _____ **STATE:** ___ **ZIP:** _____

PHONE NUMBER: (Home) _____ (Work) _____ (Cell) _____

SECONDARY PERSON TO NOTIFY: _____

TELEPHONE NUMBER: (Home) _____ (Work) _____ (Cell) _____

MEDICAL CONDITIONS OF PARTICIPANT: _____

MEDICATIONS PARTICIPANT IS ALLERGIC TO _____

MEDICATIONS PARTICIPANT IS CURRENTLY TAKING _____

PARENTAL PERMISSION

I understand that Wayne Community College does not carry any health, accident, or other similar insurance for students involved in student camps and that Wayne Community College assumes no liability for any such medical expenses. Based on this understanding, I certify as follows:

() My student is covered under my personal insurance policy that is current and now in effect.

Company: _____

Policy or Claims No.: _____

() My student is covered under medical services provided through the United States Military and/or other governmental agency or organization, or otherwise through my employment.

Company: _____

Policy or Claims No.: _____

() My student has no medical insurance coverage and I agree to be fully responsible for all uninsured expenses for medical services and treatment resulting from any accident or injury during the camp.

I GRANT PERMISSION for my child, _____ to participate in the planned student camp named above. As the custodial parent, I hereby give permission for my child to receive proper medical attention while attending this camp, and authorize those supervising the camp to do any acts and give any required consents which may be necessary or proper to provide for the health care of my child/children at any hospital or other institution by any physician, dentist, nurse or other person whose services may be needed for such health care. This consent to provide health care shall be effective with the date the camp commences and extend through the last day of the camp.

Parent/Guardian Signature

Date