



# 2017 THANKSLIVING CAMP REGISTRATION FORM

CAMP DATES: **NOVEMBER 19 - 21, 2017**

**6<sup>th</sup>-12<sup>th</sup> grades @ Lake Aurora**

**Fee: \$100 (Campers) \$50 (Leaders)**

*There is a \$20 late fee for registrations turned in after November 10<sup>th</sup>*

NAME \_\_\_\_\_ Male Female

ADDRESS \_\_\_\_\_

Mailing Address

City

State

Zip

HOME PHONE \_\_\_\_\_ CELL PHONE (leaders) \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ **2017/2018 School Grade** (or "L" for Leaders) PLEASE PUT GRADE \_\_\_\_\_

T-SHIRT SIZE: (Circle one) S M L XL XXL XXXL

CHURCH YOU REGULARLY ATTEND \_\_\_\_\_

LIST ANY AREAS THAT WOULD PERTAIN TO THIS CAMP IN WHICH YOU HAVE HAD EXPERIENCE.

\_\_\_\_\_

EMERGENCY CONTACT PERSON(S)

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phones \_\_\_\_\_ Home \_\_\_\_\_  
Cell \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phones \_\_\_\_\_ Home \_\_\_\_\_  
Cell \_\_\_\_\_

FAMILY PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

INSURANCE PROVIDER \_\_\_\_\_

POLICY NO. or GROUP NO. \_\_\_\_\_

Please list any medical allergies, medications being taken, medical problems, or other pertinent information:

\_\_\_\_\_

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Office use: Paid: cash ck# \_\_\_\_\_ Receipt \_\_\_\_\_ Computer \_\_\_\_\_ Confirmation \_\_\_\_\_

**READ THIS FORM COMPLETELY AND CAREFULLY. (LEADERS IN ITALICS)**

YOUR CHILD’S (YOUR) PHOTOGRAPH MAY BE USED IN FUTURE CARE CENTER PUBLICATIONS.

I (WE) UNDERSTAND THAT IN THE EVENT MEDICAL TREATMENT IS REQUIRED FOR MY CHILD, EVERY EFFORT WILL BE MADE TO CONTACT ME. HOWEVER, IF I CANNOT BE REACHED, (IF I REQUIRE MEDICAL ATTENTION AS A CAMP LEADER) I GIVE MY PERMISSION TO THE STAFF OR SPONSOR TO SECURE THE SERVICES OF A LICENSED PHYSICIAN AND/OR OTHER NECESSARY HEALTH CARE PROVIDER TO PROVIDE THE CARE NECESSARY, INCLUDING ANESTHESIA, FOR MY CHILD’S (MY) WELL-BEING.

YOU ARE AGREEING TO LET YOUR MINOR CHILD (YOURSELF) ENGAGE IN A POTENTIALLY DANGEROUS ACTIVITY. YOU ARE AGREEING THAT, EVEN IF LAKE WALES CARE CENTER USES REASONABLE CARE IN PROVIDING THIS ACTIVITY, THERE IS A CHANCE YOUR CHILD (YOU) MAY BE INJURED BY PARTICIPATING IN THIS ACTIVITY BECAUSE THERE ARE CERTAIN DANGERS INHERENT IN THE ACTIVITY. BY SIGNING THIS FORM, YOU ARE GIVING UP YOUR CHILD’S (YOUR) RIGHT TO RECOVER FROM LAKE WALES CARE CENTER, OR VOLUNTEERS OR STAFF THEREOF, IN A LAWSUIT FOR ANY PERSONAL INJURY TO YOUR CHILD (YOURSELF) OR ANY PROPERTY DAMAGE RESULTING FROM THE RISKS THAT ARE A NATURAL PART OF THE ACTIVITY. YOU HAVE THE RIGHT TO REFUSE TO SIGN THIS FORM, AND LAKE WALES CARE CENTER HAS THE RIGHT TO REFUSE TO LET YOUR CHILD (YOU) PARTICIPATE IF YOU DO NOT SIGN THIS FORM.

Parent/Guardian (or self if 18 or over):

\_\_\_\_\_ (print) \_\_\_\_\_ (sign)

STATE OF FLORIDA  
COUNTY OF POLK

The foregoing instrument was acknowledged before me this \_\_\_\_ day of \_\_\_\_\_, 2017, by \_\_\_\_\_, who is personally known to me or who has produced \_\_\_\_\_ as identification and who did not take an oath.

\_\_\_\_\_  
Notary Public/State of  
Florida at Large

My Commission Expires: \_\_\_\_\_

(SEAL)

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Return to: Lake Wales Care Center  
140 E. Park Ave.  
Lake Wales, FL 33853-4124  
863-676-6678