



# 2017 STAY-AT-HOME WORK CAMP REGISTRATION FORM

140 E Park Ave. Lake Wales, FL 33853-4124 863-676-6678

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

ADDRESS \_\_\_\_\_  
Mailing Address City State Zip

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

BIRTHDATE \_\_\_\_\_ **2016/2017 School Grade** ("L" for Leaders) PLEASE PUT GRADE

E-MAIL \_\_\_\_\_

Which camp(s) will you attend?

			Campers	Leaders
_____ <b>Camp 1</b>	June 12 - June 17	Completed 9 <sup>th</sup> – 12 <sup>th</sup> grades @ Camp Endeavor	\$200 <i>Registrations due June 2</i>	\$100
_____ <b>Camp 2</b>	June 26 – June 30	Completed 6 <sup>th</sup> – 8 <sup>th</sup> grades @ h.e.a.r.t Village	\$125 <i>Registrations due June 16</i>	\$75
_____ <b>Camp 3</b>	July 10 – July 15	Completed 6 <sup>th</sup> – 12 <sup>th</sup> grades @ h.e.a.r.t Village	\$150 <i>Registrations due June 30</i>	\$75
_____ <b>Camp 4</b>	July 24 – July 29	Completed 6 <sup>th</sup> – 12 <sup>th</sup> grades @ h.e.a.r.t Village	\$150 <i>Registrations due July 14</i>	\$75

***THERE IS A \$20 LATE FEE FOR ALL REGISTRATIONS TURNED IN AFTER THE DUE DATE***

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

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

EMERGENCY CONTACT PERSON(S)

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone(s) \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone(s) \_\_\_\_\_

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 \_\_\_\_\_

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

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