

## SPRING BREAK DAY CAMP REGISTRATION FORM

**Please check a day camp:**

Register for individual days:

April 2  April 3  April 4  April 5  April 6  April 9

Register for entire 6-day camp:  April 2-6 and 9, 2012

**Please check attendance option:**

- Full day (ages 6-13) - \$40  
 Half day tot (ages 3-5)\* - \$30  
 Half day tot - extended (ages 3-5)\* - \$35

**Special features:**

- Extended care service for ages 6-13 only - \$10  
 Lunch - \$6

\*Please note: children must be fully potty-trained to attend day camp.

**Participant Information**

Email Address (To receive special program notices and discounts) \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Date of Birth (MM/DD/YYYY) \_\_\_\_\_ Age \_\_\_\_\_ Circle: Male Female

Emergency Contact Name \_\_\_\_\_ Relation \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**If participant is under age 18, this information is required:**

Parent(s) \_\_\_\_\_  
NAME

NAME

HOME PHONE WORK PHONE

HOME PHONE WORK PHONE

**PLEASE COMPLETE MEDICAL INFORMATION ON REVERSE SIDE OF THIS FORM**

**PAYMENT METHOD**  MasterCard  Visa  Cash  Check # \_\_\_\_\_

Name As It Appears On Card \_\_\_\_\_

Card Number \_\_\_\_\_ Exp Date \_\_\_\_\_ CVC \_\_\_\_\_

Signature of Cardholder \_\_\_\_\_ Date \_\_\_\_\_

**FOR OFFICE USE ONLY**

Date Paid \_\_\_\_\_ Staff \_\_\_\_\_

Input Date \_\_\_\_\_

EZF Category \_\_\_\_\_

**ASSUMPTION AND RELEASE OF LIABILITY:**

Assumption and release of liability: The use of fitness equipment, participating in fitness programs, and playing contact sports such as ice hockey, soccer, field hockey, lacrosse, basketball, and others are inherently dangerous. The undersigned, on behalf of the undersigned and the undersigned's child (collectively "Participant") hereby: (1) assume the risk of personal injury, property damage, or other loss (collectively "Injuries") to the Participant arising from or related to the activities conducted and services provided at Body Zone Sports and Wellness Complex; (2) unconditionally waive, release, and discharge WRC Sports and Fitness Limited Partnership and its agents, Commonwealth Orthopedic Associates, Inc. and their agents, employees, staff members, officers, directors, partners, members (collectively the "Released Parties") from all liability, claims, or responsibility for injuries to Participant; (3) grant permission for Participant to participate in activities at Body Zone Sports and Wellness Complex; (4) unconditionally release the Released Parties from injury arising from any good faith acts or omissions in emergency situations and (5) give permission to the staff/and or sub contracted staff of Commonwealth Orthopedic Sports Medicine to evaluate and treat my child, while participating in activities at Body Zone.

I agree that you may photograph and/or videotape me or my child during my activities and that you retain the right to use these visual images in future literature for Body Zone Sports and Wellness Complex without compensation to me or my child. I further agree that you may use my name, my child's name, or any testimonials made by us without limitation in advertising and promoting Body Zone Sports and Wellness Complex.

I represent that I am over the age of 18 or a parent/guardian of the minor named above, and agree that the grant and release contained therein binds me and the minor of all of its terms.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(PARENT/GUARDIAN MUST BE 18 YEARS OF AGE)

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# SPRING BREAK DAY CAMP MEDICAL INFORMATION

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Physician Name \_\_\_\_\_ Phone \_\_\_\_\_

Will your child be taking medication (circle one): YES NO If yes, what type? \_\_\_\_\_  
Please send all medication in a clear Ziploc bag with a label and specific instructions.

Does your child have any allergies (circle one): YES NO

TYPE:	EXPLAIN SYMPTOMS AND SEVERITY:
<input type="checkbox"/> Bee sting	_____
<input type="checkbox"/> Peanut/Nut	_____
<input type="checkbox"/> Drugs	_____
<input type="checkbox"/> Food	_____
<input type="checkbox"/> Other	_____

Does your child have chronic or recurring illness (circle one): YES NO

TYPE	PLEASE EXPLAIN IN DETAIL:
<input type="checkbox"/> Asthma	_____
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Seizures	_____
<input type="checkbox"/> Cardiac	_____
<input type="checkbox"/> Other	_____

Are there any limitations/issues we should be aware of (circle one): YES NO

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

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## PICKUP CONSENT

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I give permission for the following persons to pick up my child(ren) from camp. (PHOTO I.D. REQUIRED)

NAME \_\_\_\_\_ PHONE \_\_\_\_\_

NAME \_\_\_\_\_ PHONE \_\_\_\_\_