Camp Quien Sabe "Overnight Camp" Registration Form

For more information on Camp Quien Sabe, turn to page 14.

PLEASE CHECK DATES YOU WILL BE ATTENDING CAMP QUIEN SABE.

❑ 1. June 23-27
❑ 2. June 30-July 3 *(4 days)*
❑ 3. July 7-11
❑ 4. July 15-18 *(4 days)*
❑ 5. July 21-25
❑ 6. July 28-August 1 *(only prior attendees)*

FEE: $225 per session
$180 *(Weeks 2&4)*

PLEASE CHECK THE APPROPRIATE AGE CATEGORY
❑ Regular Camp *(entering 2nd grade – 11 yrs)*
❑ Environmental Team Camp *(12 yrs)*
❑ Work Experience Camp *(13–15 yrs)*

HAS YOUR CHILD EVER ATTENDED CAMP QUIEN SABE? ❑ YES ❑ NO IF YES, WHAT WAS THE LAST YEAR ATTENDED? _____

CHILD'S FIRST NAME _____ LAST _____ ❑ M ❑F

HOME ADDRESS _____ CITY_____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE_____

AGE_____BIRTH DATE: MO_____DAY_____YEAR_____SCHOOL_____GRADE ENTERING IN FALL 2008 _____

If a friend will be attending with you and you wish to be placed in the same group, please give name of friend:

_____

Every effort will be made to put friends together if they are of the same age, however we cannot assure such placement. Groupings of more than two children will not be considered.

DOCTOR'S NAME _____ PHONE_____

OFFICE ADDRESS _____

IN CASE OF AN EMERGENCY AND WE ARE UNABLE TO REACH YOU, PLEASE LIST TWO OTHER CONTACTS. PLEASE NOTIFY PEOPLE BEING LISTED.

NAME _____ RELATIONSHIP _____ PHONE_____

NAME _____ RELATIONSHIP _____ PHONE_____

MEDICAL INSTRUCTIONS: DATE OF LAST TETANUS IMMUNIZATION _____

(Verify with doctor and update, if needed) PLEASE LIST ANY SPECIAL PROBLEMS, ALLERGIES, ETC., THAT YOU FEEL WE SHOULD KNOW ABOUT:

_____

_____

IS YOUR CHILD A VEGETARIAN? ❑ YES ❑ NO

WILL YOUR CHILD BRING ANY SPECIAL MEDICATION TO CAMP? ❑ YES ❑ NO

If yes, please give specific directions for administration and dosage. Contact Camp Directors to discuss any problems. In the event we should need to bring your child back to town due to illness, we shall attempt to contact you (or people listed) immediately to notify you of our actions. In the case of medical care, we shall attempt calling you from camp. We shall transport your child home or to a mutually agreed upon location or, if need be, to the nearest emergency room where your child's doctor will be contacted and emergency care will be given.

AUTHORIZATION TO TREAT: I authorize the adult agents and employees of the Monterey Recreation & Community Services Department in charge of the program to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care to be rendered to my above named minor child under the general special supervision and upon the advice of a physician and surgeon licensed under the provision of the Medical Practice Act, pursuant to Section 25.8 of the California Civil Code and agree to be responsible for all cost thereby incurred.

The undersigned, in consideration of participation in this program, agrees to indemnify, hold harmless and release the City of Monterey, its agents and employees, from any and all liability for any injury which may be suffered by the above named individual registered in this program arising out of or in any way connected with participation in this program. I have read the above application and agreement and fully understand that I assume all risks for any injuries received.

❑ PARENT ❑ GUARDIAN SIGNATURE **X** _____

PLEASE PRINT YOUR NAME **X** _____

REFUND POLICY: (APPLICABLE TO ALL PROGRAMS) NO REFUNDS AFTER PROGRAM BEGINS. A 25% SERVICE CHARGE WILL BE APPLIED TO REFUNDS BEFORE PROGRAM BEGINS.

Rules for acceptance and participation in this program are the same for everybody without regard to race, color, national origin, age, sex or handicap.

All campers must be dropped off and picked-up at the Recreation & Community Service Office. No one will be allowed to be dropped off or picked-up at camp.

MAIL-IN FORMS. NOTE: It is essential that you enclose a return self-addressed stamped envelope along with this form and payment. Additional camp information will be forwarded along with our receipt of registration. Mail forms to us at: 546 Dutra Street, Monterey, CA 93940.

METHOD OF PAYMENT: ❑ MasterCard ❑ Visa ❑ American Express

_____ – _____ – _____ – _____ Exp. Date_____

Name of card holder _____ Signature _____

(Please print)