



# EDGEMOOR SUMMER OF DISCOVERY CAMP

Registration Form

## PARTICIPANT INFORMATION

First Name	MI	Last Name	Gender	Birthdate	Grade in 21/22
Home Address		City	Zip	Phone (xxx) xxx-xxxx	

PLEASE SELECT T-SHIRT SIZE. (check one)  YS  YM  YL  YXL  AS  AM  AL  AXL

PLEASE ASSESS YOUR CHILD'S SWIM ABILITIES. (check one)  non-swimmer  weak swimmer  strong swimmer

## ADULT PAYEE INFORMATION

First Name	MI	Last Name	Home Phone (xxx) xxx-xxxx
Email Address		Birthdate	Cell Phone (xxx) xxx-xxxx

## EMERGENCY CONTACT INFORMATION

Parent/Guardian Name:		Parent/Guardian Name:	
Cell Phone:		Cell Phone:	
Home Address		Home Address	
City	Zip	City	Zip

## EMERGENCY CONTACT (other than parents):

Name:	Phone:	Relationship:
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## PICK-UP AUTHORIZATIONS

I authorize only the following person(s) to pick up my child (other than parents and emergency contact).

Name: _____	Phone Number: _____	Relationship: _____
Name: _____	Phone Number: _____	Relationship: _____
Name: _____	Phone Number: _____	Relationship: _____

## SPECIAL HEALTH CONSIDERATIONS:

Allergies, physical limitations, etc.:

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Current Medications:

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**\*Medications cannot be administered in camp without a completed Medication Release Form on file from doctor.**

Scholarships possible through the Community Services Block Grant (CSBG) and the Kansas Housing Resources Corporation (KHRC)

**\*\*\*Late Fees: After 6:00pm Guardians will be charged \$1.00 per minute per child. After 6:30pm Wichita Police will be notified**



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## PAYMENT AGREEMENT

Payment Schedule	1 <sup>st</sup> Child	2 <sup>nd</sup> Child	3 <sup>rd</sup> Child+ (per child)
Full Week Fee	\$115	\$105	\$95
May 31 – June 3	\$92	\$82	\$72
June 21 –24	\$92	\$82	\$72
July 6 – 8	\$69	\$59	\$49

- I understand that as an SOD Program Registrant, a \$20 deposit per week per child is due to at the time of registration to reserve a spot for each week I want to enroll my child in. Deposits are non-refundable and non-transferable. \*(Deposits are included in the cost of the weekly fee – not in addition to.)
- The weekly fee is **due the Friday prior to the week attending camp.**
- Weekly fees can be paid in a lump sum when registering, monthly, bi-weekly, or weekly.
- Failure to pay weekly fees in a timely manner will result in termination of services until payments due are paid in full.
- If the child fails to attend two consecutive weeks without notifying the center, they will be withdrawn from camp and deposits will be forfeited.

\_\_\_\_\_  
Signature of Parent/Guardian                      Date

\_\_\_\_\_  
Signature of Center Director                      Date



**AUTHORIZATION FOR EMERGENCY MEDICAL CARE**

Written permission for emergency medical treatment must be on file at the facility. Consult with the local emergency medical facility to be sure this form is acceptable. Reference K.A.R. 28-4-127(b)(1)(A). School Age Programs reference K.A.R. 28-4-582(e)(2).

Name of facility exactly as stated on the license. <b>Edgemoor Recreation Center SAC</b>	License # <b>0000155-014</b>
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I authorize Edgemoor Recreation Center Staff (caregiver/staff) who is (are) representative(s) of the above-named facility to give consent for any and all necessary emergency medical care for my child or youth \_\_\_\_\_ (child's first and last name) while child or youth is in the facility's custody  
Between 05/31/2022 and 07/29/2022.  
MM/DD/YYYY MM/DD/YYYY

Is child covered by health insurance?  Yes  No

If yes, complete the following:

Health Insurance Policy Name \_\_\_\_\_ Policy Number \_\_\_\_\_

Medical Assistance Program \_\_\_\_\_ Card Number \_\_\_\_\_

Military Medical Care I.D. Number \_\_\_\_\_

If known, date of last Tetanus inoculation: \_\_\_\_\_  
MM/DD/YYYY

List any known allergies or other information about the medical conditions of this child or youth pertinent in case of emergency:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Parent or Guardian	Date Signed
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Witness to Parent's or Guardian's signature if required by the local hospital or clinic.	Date Signed
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Notarization of Parent's or Guardian's signature if required by local hospital or clinic.

~~State of Kansas  
County of \_\_\_\_\_  
Signed or attested before me on \_\_\_\_\_ by \_\_\_\_\_  
MM/DD/YYYY Name of Person  
(Seal, if any.)  
Signature of Notarial officer  
\_\_\_\_\_  
Title (and Rank)  
My appointment expires: \_\_\_\_\_~~

The Medical Record/Assessment Form (Or Health Status History form for School Age Programs) and the authorization for Emergency Medical Care must be taken to the emergency room. Both forms must also be in a vehicle when the child or youth is transported by the facility.