

## Summer Camp Registration

Mail to: Ridgefield Community Education, 2724 S. Hillhurst Road, Ridgefield WA 98642

Name (First) \_\_\_\_\_ (Last) \_\_\_\_\_

Registering for: (Please List) \_\_\_\_\_

Age \_\_\_\_\_ Entering Grade \_\_\_\_\_ School \_\_\_\_\_ Shirt Size YM YL AS AM AL AXL

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home# \_\_\_\_\_ Cell# \_\_\_\_\_ Work# \_\_\_\_\_

Parent/Guardian Names \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone# \_\_\_\_\_

Email address \_\_\_\_\_ Do you want to be on our mailing list? Yes No

Parent Permission:

\_\_\_\_\_ has my permission to participate in the Ridgefield Summer Camp Program. In an emergency, I grant permission for emergency treatment to be administered to my child. I agree to pay all medical bills not covered by my insurance company. I release Ridgefield School District from responsibility for any bills resulting from injuries incurred in this program. While no sports physical is required to participate, I understand that my child should be in good physical condition and that a current medical exam is recommended. I understand the risks of participating in this sports activity. I have listed information regarding allergies and/or medical conditions about my child of which staff should be aware.

Does your child have any allergies or medical conditions that staff should be aware of? Yes No

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

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

Insurance Company \_\_\_\_\_ Policy# \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone# \_\_\_\_\_

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