SFB SUMMER CAMP - Edible Science & Movie Making
REGISTRATION DEADLINE: Wednesday, March 27th - Dates: 7/1/19 - 7/5/19
ONE FORM PER STUDENT

Participant Information					
Name of Child				DOB	
List any health conditions of which we should be informed				Grade Fall 2017	
List any dietary restrictions, allergies or medical conditions				Male or Female	
Parent Information					
Name of Parent or Guardian				Relationship	
Work Telephone		Home		Cell	
Home Address		City		Zip code	
Email Address					
Occupation					
Emergency Contact Information					
Emergency Contact				Relationship	
Work Telephone		Home		Cell Phone	
Street Address		City		Zip code	
Email Address					
Persons Authorized to pick up your child or children anytime (in addition to the names mentioned above)					
Name				Relationship	
Work Telephone		Home		Cell Phone	
Medical Information					
Health Insurance Company					
Doctor		Telephone			
Dentist		Telephone			

Program	**Program Provider**	**Fees**
SFB Summer Camp	SFB	$290

FINE PRINT
I understand and acknowledge that participation in these enrichment programs include activities that can result in physical injuries. I authorize the child/children named above to participate in all activities. On my own behalf and on behalf of the Child/children named above, I expressly and voluntarily assume the risks of these activities and hereby waive and release all claims (whether on behalf of the child/children named above or for my own benefit) against St. Finn Barr and the Program Providers (including its staff, employees, and agents) that may arise from injuries as a result of participating in activities, to the fullest extent allowed under California Law. If any aspect of this waiver is deemed to be invalid, I acknowledge that the remainder of the agreement will continue to have full force and effect. I hereby authorize the staff of the Programs to act according to their best judgment in any emergency or other situation requiring medical attention for the child/children named above. I understand that it is my responsibility to provide medical insurance coverage for the child/children named above while they are attending and to provide accurate and complete medical information. I acknowledge that the cost of any medical treatment provided to the child/children named above that are not covered by medical insurance will be my sole responsibility, consistent with the waiver of claims above. I agree that photos, video, and audio recordings including the child/children named above may be used by the Program for marketing purposes.
I hereby grant permission for my child to participate in the selected Programs.

Signature		Date	

FINAL INSTRUCTIONS

1. Complete one form per child participant.
2. Checks should be made payable to St. Finn Barr.
3. Please notate the participant's name on the check/money order.
4. Return the completed form to the St. Finn Barr office.