

St. Finn Barr Catholic School
Preparing young, diverse minds for the future

SFB SUMMER CAMP - Steam/Maker's Space
REGISTRATION DEADLINE: Wednesday, March 27th - Dates: 6/24/19 - 6/28/19
ONE FORM PER STUDENT

Participant Information

Name of Child		DOB	
List any health conditions of which we should be informed		Grade	
List any dietary restrictions, allergies or medical conditions		Fall 2017	
		Male or Female	

Parent Information

Name of Parent or Guardian		Relationship	
Work Telephone		Home	
Home Address		City	
Email Address			
Occupation			

Emergency Contact Information

Emergency Contact		Relationship	
Work Telephone		Home	
Street Address		City	
Email Address			

Persons Authorized to pick up your child or children anytime (in addition to the names mentioned above)

Name		Relationship	
Work Telephone		Home	

Medical Information

Health Insurance Company			
Doctor		Telephone	
Dentist		Telephone	

Program	Program Provider	Fees
SFB Summer Camp	SFB	\$315

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	
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- 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.