



## Summer Camp Registration

**Please register for camp as soon as possible by returning this form with a \$50 deposit. The balance is due by Friday, July 22. As camp time approaches, we will send you a daily camp schedule and a list of what your child will need.**

Camper's Name \_\_\_\_\_ Date \_\_\_\_\_

Camper's age at time of camp: \_\_\_\_\_ Camper's Date of Birth \_\_\_\_\_ Sex: M F

**The camp session runs from July 25 – 29 from 9 – 1 each day except for Wednesday, when camp runs from 9 – 7. The cost is \$145.**

Name of Parent or Guardian \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
\_\_\_\_\_ Work Phone \_\_\_\_\_  
\_\_\_\_\_ E-mail address \_\_\_\_\_

If not the above, whom should we contact in case of emergency? \_\_\_\_\_

Relation of contact to camper: \_\_\_\_\_ Emergency Phone \_\_\_\_\_

School camper attends: \_\_\_\_\_ Going into which grade? \_\_\_\_\_

If you have prior experience in Taekwondo, what is your rank? \_\_\_\_\_

If your child is not a student at Taekwondo West, how did you hear about our camp? \_\_\_\_\_

Is there anything else you would like us to know about you/your child?

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**Please fill out reverse side**

## Camper Health Informaton

Does your child have any of the following allergies?

Hay fever   
Bee stings   
Insect bites   
Penicillin   
Peanuts

Other allergies (please specify):

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Has your child had any of the following?

Chicken Pox   
Tuberculosis   
Epilepsy   
Hepatitis   
Mononucleosis

Other, including any heart condition, lung condition, chronic or recurring illness: (please specify):

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Does your child have asthma?      Yes    No

Does your child wear glasses or contact lenses?    Yes    No

Is your child taking any prescribed medication?    No    Yes -- If yes, please list all medications taken routinely and reason: \_\_\_\_\_

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I hereby give permission for Taekwondo West to dispense prescribed medications to my child.

Parent or Guardian's name: \_\_\_\_\_ Signature: \_\_\_\_\_  
Date: \_\_\_\_\_

Has your child ever been hospitalized? If so, please indicate when and for what condition: \_\_\_\_\_

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Is there any other information we should know about your child? \_\_\_\_\_

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Local doctor's name: \_\_\_\_\_ Doctor's telephone number: \_\_\_\_\_

I hereby swear that all the foregoing information is true and correct to the best of my knowledge.

Parent name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

In the event that my child needs immediate medical care and neither parent nor the child's local doctor is available, I authorize Taekwondo West to seek emergency treatment at Bozeman Deaconess Hospital and to have a doctor or nurse administer necessary medical treatment and/or to have necessary X-rays taken for emergency care.

Parent/Guardian name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Policy #: \_\_\_\_\_

Insurance Phone Number: (      ) \_\_\_\_\_

Claimant's Name (Print): \_\_\_\_\_

Claimant's Signature (for care): \_\_\_\_\_