Summary Camp Student Enrollment Form

Wellspring United Methodist Church 10701 Sheldon Rd. Tampa, FL 33626 Ph 926-5006

Please mail or deliver this form to Wellspring to reserve your spot

Child's Name ______________________________

My child will be attending the following camps: (Please check all that apply)

☐ **June 21 – June 25** ***Kids Cook I***	Anticipated After-care Days*	M	T	W	TH	F	None
☐ **June 28 – July 2** ***Kids Cook II***	Anticipated After-care Days*	M	T	W	TH	F	None
☐ **July 5 – July 9** ***Lights, Camera, Action***	Anticipated After-care Days*	M	T	W	TH	F	None
☐ **July 12 – 16** ***Cartoon Creations***	Anticipated After-care Days*	M	T	W	TH	F	None
☐ **August 9 – 13** ***2 Cool 4 School***	Anticipated After-care Days*	M	T	W	TH	F	None

Camp Hours are from 9am – 2 pm Mon. – Fri. ***After-care will be available until 6pm on all camp days for $5/hr. We ask that you indicate your anticipated needs on this form but will be given the opportunity to confirm your days needed weekly throughout the summer. After-care services must be scheduled and paid for in advance. Fees are due no later than Monday morning of the week services are to be rendered.**

Weekly Camp Fees (includes lunch): 1 wk - $130 2 wks - $125 ea 3+ wks - $120 ea

Total # of camp weeks my child will attend: ________ **X** weekly camp fee $ __________ = $ ______________

10% sibling discount (does not apple to 1st child) $______________

One time registration fee (includes t-shirt)$ ____**$20**____

Total Fees Paid $ _____________

T-Shirt Size Please circle one: *YOUTH* S M L XL *ADULT* S M L XL

Please Make Checks Payable to ***Wellspring Enrichment Program*** or complete below for credit card payment.

Credit Card

Payment Amount $____________________

Please check which credit card to use: _______ VISA _______ MasterCard _______Discover

Credit Card # ____ Expiration Date________________________________

Name as it appears on credit card ____

Billing Address ____

Home Phone______________________________ Email Address ____

I authorize Wellspring Enrichment Program and Vanco Services, LLC to charge my credit card in accordance with the information above.

Authorized Signature ____ Date _____________________________

Summary Camp Student Information Form

Wellspring United Methodist Church
10701 Sheldon Rd. Tampa, FL 33626
Ph 926-5006

*****Please mail or deliver this form to Wellspring to reserve your spot*****

CHILD'S NAME: ____ PREFERRED NAME: ____________________________

DOB: _________________ GRADE 2009-2010: __________ SEX: ________ DATE ENROLLED: ________________________

ELEMENTARY SCHOOL: ________________________________ PARENT'S EMAIL: ______________________________

ADDRESS: ____ ZIP CODE: _____________________

MOTHER'S NAME: _____________________________________ FATHER'S NAME: _______________________________

CUSTODIAL PARENT (CIRCLE ONE): MOTHER FATHER JOINT

HOME PHONE: ____ HOME PHONE:__________________________________

EMPLOYMENT: ____ EMPLOYMENT: _________________________________

WORK PHONE: ____ WORK PHONE: ________________________________

PERSONS AUTHORIZED TO REMOVE CHILD OTHER THAN PARENTS (IDENTIFICATION REQUIRED)

1. ____

NAME RELATIONSHIP PHONE

2. ____

NAME RELATIONSHIP PHONE

<u>NUTRITIONAL PLAN AGREEMENT</u>

I understand that Wellspring Enrichment Program will provide, through local restaurants, lunch on all camp days. Afternoon snack will be provided for students participating in after-care. If my child has dietary restrictions that prevent him/her from participating in this meal program, I agree to provide the following meals and/or snacks to meet my child's nutritional and dietary needs.

(Mark P if Parent will provide or C if Center may provide) Lunch: __________ Afternoon Snack: __________

Indicate Special Dietary Requirements: ____

____

As parent or legal guardian of __________________________ I certify that all the information on this form is complete and accurate.

____

Signature of Parent or Legal Guardian

MEDICAL NEEDS AGREEMENT

Medical Alert Information (i.e., allergies, medical and/or handicapping conditions): ____

____

List any additional information which would be beneficial for the child care staff to know about your child: ____________________

____

Preferred Physician: ____

Address: ____ Phone: __________________________________

Preferred Hospital: ____

EMERGENCY CONTACT (OTHER THAN PARENTS):

1. ____
   NAME RELATIONSHIP PHONE

2. ____
   NAME RELATIONSHIP PHONE

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

If my child, ____, should become ill or
CHILD'S FULL NAME

Injured at, ____, I understand that the
NAME OF FACILITY

Facility will: (1) Contact me immediately and (2) Contact the person (s) I have designated if I cannot be reached.

Should the facility be unable to reach me and/or the person(s) designated, they are authorized to contact my child's physician and/or arrange for immediate medical treatment.

The physician and/or medical facility are authorized to administer emergency medical treatment necessary to ensure the health and safety of my child.

I will accept responsibility for payment of medical services rendered.

____
SIGNATURE RELATIONSHIP DATE