



**Camper**

First \_\_\_\_\_ M.I. \_\_\_ Last \_\_\_\_\_ Gender: M F  
School Name \_\_\_\_\_ Grade \_\_\_\_\_  
Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_ Phone # \_\_\_\_\_  
E-mail \_\_\_\_\_

**Parent/Guardian - Contact Information**

**Parent/Guardian #1**

Name \_\_\_\_\_ Ms. Mrs. Mr. Other \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_ Zip Code \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Cell phone \_\_\_\_\_  
E-mail \_\_\_\_\_

**Parent/Guardian #2**

Name \_\_\_\_\_ Ms. Mrs. Mr. Other \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_ Zip Code \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Cell phone \_\_\_\_\_  
E-mail \_\_\_\_\_

**Person responsible for payment:**

\_\_\_\_\_

**Emergency Contact Information-**

**Emergency Contact #1**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Email \_\_\_\_\_ Relation to child \_\_\_\_\_

**Emergency Contact #2**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Email \_\_\_\_\_ Relation to child \_\_\_\_\_





**Medical Release Information**

Insurance Information

Policy Number \_\_\_\_\_

Name of Health Insurance Provider \_\_\_\_\_

Primary Physician \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Hospital Preference \_\_\_\_\_

Please list any medical issues, including any requiring maintenance medication (i.e. Diabetic, Asthma, Seizures).

Medical Issues

Required treatment/Medication

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Is your child presently being treated for an injury or sickness, and is taking any form of medication for it?

Yes No If yes, explain: \_\_\_\_\_

Is your child allergic to any type of food or medication?

Yes No If yes, explain: \_\_\_\_\_

Does your child require a special diet?

Yes No If yes, explain: \_\_\_\_\_

The purpose of the above listed information is to ensure that medical personnel have details of any medical problem which may interfere with or alter treatment.

**In case of medical emergency contact:**

	Name	Phone #	Relationship to Child
Contact #1			
Contact #2			
Contact #3			





I understand that I will be notified in the case of a medical emergency involving my child. In the event that I cannot be reached, I authorize the calling of a doctor and the providing of necessary medical services in the event my child is injured or becomes ill.

Parent's/Guardian's Initials \_\_\_\_\_

I understand that VIP 305 Miami will not be responsible for the medical expenses incurred, but that such expenses will be my responsibility as parent/guardian.

Parent's/Guardian's Initials \_\_\_\_\_

### Terms of Agreement

#### Photo Release

I hereby give permission for my child to be photographed during the **VIP 305 Miami Sleep-away Summer Camp Service Project**. I understand the photos will be used to keep a journal of activities, to share in our magazine and for promotional purposes including flyers, brochures, our social media and on our website. I do not expect compensation and that all photos are the property of VIP 305 Miami and its affiliates.

Parent's/Guardian's Initials \_\_\_\_\_

#### Transportation Release

I hereby give permission for the transportation of my child for official **VIP 305 Miami Sleep-away Summer Camp Service Project** activities by modes of transportation agreed to by the camp organizers.

Parent's/Guardian's Initials \_\_\_\_\_

VIP 305 Miami and its co-organizers are not responsible for lost or damaged personal property. All scheduled events are subject to change. I understand that no fees will be refunded or transferred unless a child is unable to participate due to an accident or illness per physician orders. Children's' photos and quotes may be used for publicity purposes. In case of an emergency, and if a family physician cannot be reached, I hereby authorize my child to be treated by Certified Emergency Personnel (i.e. EMT, First Responder, and/or Physician).





Guardian Signature: \_\_\_\_\_

Printed Name of Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

### Card Holder Information

Name: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Country: \_\_\_\_\_ Email \_\_\_\_\_

Address: \_\_\_\_\_

Direct Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

I hereby affirm that I am the owner of the below referenced credit card and that my name is listed on the front of the credit card.

I hereby authorize **VIP 305 Miami** to charge my credit card (below) in the amount of \$\_\_\_\_\_ for payment of **VIP 305 Miami Sleep- away Summer Camp Service Project**.

Account Holder Signature \_\_\_\_\_

### Credit Card Information

Credit Card Type:  MasterCard  Visa  American Express  Discover Card

Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Security Code: \_\_\_\_\_

Cardholder Signature X \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

