

Stars 'n Stripes Summer Camp 2008

Complete and return this form to the Youth Desk.

DANCE MADNESS WORKSHOP

7- to 12-years-old
Monday to Friday
9:30 a.m. - 3:45 p.m.
\$450 per week

Name of Participant: _____ DOB: _____ Gender: _____

Name of School: _____ (DD/MM/YY) (M/F)

Camp 1 - June 17 - 20
*(No camp on June 16 due to Club closure
for Staff Family Fun Day)*

Camp 2 - July 14 - 18

Parent/Guardian's Name: _____ Membership No: _____

Home Address: _____

Telephone No: (1) _____ (2) _____ (3) _____

Emergency Contact Person: _____ Telephone No: _____

Email: _____

Signature of Parent/Guardian: _____ Submission Date: _____

CANCELLATION POLICY:

- UPON RECEIPT of registration form: 20% of camp fee (non-refundable)
- Less than one week before camp: 50% of camp fee
- Less than 48 hours before camp commencement: 100% of camp fee

Liability Waiver: The American Club, its servants or agents, the General Committee or Club Trustees or any of them is not responsible or liable to any person participating in the program activity for any death, injury, damage or loss suffered by or caused to such person in the course of participation. The undersigned hereby undertakes to indemnify The American Club, its servants or agents, the General Committee or the Club Trustees against all claims brought against them arising out of death, injury, damage or loss suffered or caused in the course of participation. This includes all costs and expenses incurred as a result of such claims.

Pro-Rata Billing: Please note there is no pro-rata billing for camp days missed through illness, unless a medical certificate is received. Members unable to attend the camps due to illness must advise The Club on that particular day. The certificate must be received at the Youth Desk within 48 hours of notification. Pro-rata billing will be effective if a camp day is missed due to a Public Holiday/ Club Event Day.

FOR OFFICE USE:

Date Registration Form Received: _____ Received By: _____



M E D I C A L R E C O R D
Stars 'n Stripes Summer Camp 2008
Health History

Please explain any items checked on this form. Indicate any information useful to the adult-in-charge relating to any of these health conditions. Also indicate activities to be encouraged or restricted. **Note:** This information will be kept confidential.

Participant's Name: _____

Name of Participant's Physician: _____ Telephone No: _____

Types of medications taken regularly (names): _____

Part I: Illness and injuries (Check those that apply)

- | | | | |
|-------------------------------------|---|------------------------------------|---------------------------------------|
| <input type="radio"/> Ear infection | <input type="radio"/> Bleeding/Clotting Disorders | <input type="radio"/> Hypertension | <input type="radio"/> Other (specify) |
| <input type="radio"/> Asthma | <input type="radio"/> Heart Defect/ Disease | <input type="radio"/> Hypoglycemia | _____ |
| <input type="radio"/> Diabetes | <input type="radio"/> Musculoskeletal Disorders | <input type="radio"/> Seizures | _____ |

Part II: Allergies / Special dietary restrictions (health or religious) _____

Part III: Other Health or Behavioral Conditions (Check those that apply)

- | | | |
|--|--|---|
| <input type="radio"/> Wears Glasses/Contacts | <input type="radio"/> Motion sickness | <input type="radio"/> Fainting |
| <input type="radio"/> Nosebleeds | <input type="radio"/> ADD/ ADHD | <input type="radio"/> Sickle Cell Trait/Disease |
| <input type="radio"/> Constipation | <input type="radio"/> Hearing impairment | |
- Other (specify) _____

Part IV: Immunizations: Up to Date? Yes No Date of last physical exam: _____

Child has had: measles mumps chicken pox whooping cough
Others (specify) _____

Part V: Activities restriction (if any)

(Specify): _____

In case of emergency, if I am unable to be notified, I hereby give permission to the physician selected by the adult-in-charge to hospitalize and secure proper treatment for my child.

Signature (Parent or Guardian): _____ Date: (DD/MM/YY) _____

