

# Camp SonShine

## Registration Form

Please Print below using black or blue ink.

Office Use Only:	<input type="checkbox"/>	FEE:
<input type="checkbox"/>	S 1	<input type="checkbox"/>
		S 2

**Name of Student:**

Date of Birth	Sex	Age	Home Church:
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**Name of Parent/Guardian:**

**Address:**

<b>Home Phone:</b>		<b>Cell</b>	
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<b>Emergency Contact:</b>	Name	Relationship to Child
	Address	Cell Phone

Address	Phone	Cell Phone
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<b>Medical History &amp; Release:</b>	Preferred Hospital
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Physician Name	Physician Address:
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Physician Phone	Insurance Carrier and Policy Number
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**Medical Conditions:** Please list and conditions/restrictions that may affect your child during Camp SonShine

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**This health history is complete and accurate. My child has permission to engage in all prescribed activities, except as noted by me and/or the prescribing physician. In case of illness or injury, I give permission for him/her to receive first aid, and to receive emergency treatment from a licensed physician and/or hospital with the most reasonable access. I further release SonShine Preschool and Calvary Lutheran Church from any liability or damages, including any claim for injuries incurred by my/our child as a result in participation of programs. I furthermore understand that SonShine Preschool /Calvary Lutheran Church's insurance shall be excess over any other valid and collectible insurance to the injured person. This is subject to the insurance company's limit of liability for medical payments**

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