

SUMMER CAMP 2008 APPLICATION FORM

All Art Camp - Art Institute of Weston

CAMPER'S NAME:		
Address:		
City:	State:	Zip code:
Camper's Birthday: / /	Age:	Sex:
PARENTS		
Home phone:		Work Phone:
Mother's Name:		Father's Name:
Mother's Cellular:		Father's Cellular:
CAMPS HOURS		
(Select) 9:00AM to 3:00 PM		
Session ONE	<input type="checkbox"/>	(June 9 to June 20)
Session TWO	<input type="checkbox"/>	(June 23 to July 3)
Session THREE	<input type="checkbox"/>	(July 7 to July 18)
Session FOUR	<input type="checkbox"/>	(July 21 to August 1)
EXTENDED HOURS		
(Select)		
<input type="checkbox"/>	8:00am to 3:00pm	add. \$15.00 per week
<input type="checkbox"/>	8:00am to 4:00pm	add. \$30.00 per week
<input type="checkbox"/>	9:00am to 4:00pm	add. \$30.00 per week
<input type="checkbox"/>	9:00am to 5:00pm	add. \$30.00 per week
NO REFUND AND OR MAKE-UP CLASSES		
Any medical problems:		
(Explain here)		

I hereby give permission to the **ART INSTITUTE OF WESTON** and/or its designee to ensure that medical intervention/treatment of my child is given by Emergency personnel to ensure that my child receives the proper medical treatment, under provision of the **Medical Practice Act**; in my absence should an injury occur. I understand that due to insurance regulations, paramedics or ambulance must transport injured or ill children to a Hospital, where necessary. **CAMP PERSONNEL CANNOT TRANSPORT THEM.** It is also my intent to grant authority to administer and perform any and all examinations including but not limited to x-ray examinations, treatment, anesthetics, and diagnostic procedures that may in the course of my

child's care be deemed advisable and necessary. I also understand and agree that I will be responsible to pay any and all charges incurred as a result of my child's treatment at the treating Hospital and/ or expense for transportation to a Hospital.

Please, list all individuals (including parents) allowed to pick up child:

1- Name:	Relationship:
2- Name:	Relationship:
3- Name:	Relationship:
4- Name:	Relationship:

I HAVE READ AND UNDERSTAND THE ABOVE POLICY, and agreed to all the rules and regulations of the Institute:

Name:	Date:
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Signature: (sign here)

Approved by:

Fax this form to fax # **954- 659-2441**

Or deliver it in person to:

THE ART INSTITUTE OF WESTON
Weston Commercial Center
Suite 1600
2900 Glades Circle
Weston, FL 33327