Synergy Health Club
by St.JosephHealth

DAY CAMP REGISTRATION

One form for each program participant. Incomplete forms will result in delay of registration. Please print and fill out completely.

DAY CAMP PARTICIPANT

Parent/Guardian Name _____ Email Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Child's Name _____ Child's Age _____ ❑ Male ❑ Female

MEDICAL INFORMATION

Health Insurance Company _____ Policy No.(s) _____

Doctor _____ Phone _____ Dentist _____ Phone _____

Medications? ❑ Yes ❑ No (if yes, reverse side must be completed)

Special Health Considerations, Disabilities, Food or Drug Allergies? ❑ Yes ❑ No (if yes, specify below)

_____

_____

Medical & Liability Waiver: *I hereby agree to accept all financial responsibility and give consent for any medical, surgical or dental attention to maintain the health of the above child named. I agree to absolve Active Acquisition Partners, LLC, Active Wellness, LLC and St. Joseph Health (dba Synergy Health Club Petaluma) and its staff from all liability that may arise as the result of participation in the programs below. I am also to report any medical problem that is serious or life threatening to the child. I agree to all policies and procedures of Synergy Petaluma.*

Model Release: *I give full and exclusive rights toSynergy Petaluma for any/all images, text and/or videos of me or my child(ren) acquired during the program(s) below, and understand said images, text and/or videos may be used by Synergy Petaluma as they see fit without any future notice or compensation. Video cameras may monitor and record on site.*

Parent/Guardian Signature _____ Date _____ Email Address _____

EMERGENCY CONTACT

Name and number of persons authorized to pick up child in case of emergency:

Name/Relationship _____ Emergency Phone _____ Alternate Phone _____

Name/Relationship _____ Emergency Phone _____ Alternate Phone _____

❑ **FULL WEEK** $250/member, $375/non-member

❑ **2-DAY OPTION** $120/member, $180/non-member

❑ **3-DAY OPTION** $165/member, $240/non-member

❑ **10% EARLY-BIRD DISCOUNT ENDS 3/31/19**

❑ **5% SIBLING DISCOUNT**

❑ **Backyard Adventures** 6/3–7 $_____

❑ **In It To Win It** 6/10–14 $_____

❑ **Movin' & Groovin'** 6/17–21 $_____

❑ **Everyday Heroes** 6/24–28 $_____

❑ **Clowning Around*** 7/1–5 $_____

❑ **Outdoor Explorers** 7/8–12 $_____

❑ **Curious Chemists** 7/15–19 $_____

❑ **Food Frenzy** 7/22–26 $_____

❑ **Art's Alive** 7/29–8/2 $_____

❑ **Splish Splash** 8/5–9 $_____

**There will be no camp on July 4th and pricing for the holiday week is $200/members and $300/non-members.*

$_____ Camp Sub-total

❑ 10% Early-Bird Discount (ends 3/31/16)

❑ 5% Off additional sibling discount

$_____ Camp Total

Synergy Petaluma is not responsible for providing make-up classes or issuing refunds for programs missed as a result of illness, travel, emergencies or other events beyond the control of Synergy Petaluma. All classes are subject to minimum enrollment. Synergy Petaluma reserves the right to cancel classes by refunding all fees where the minimum enrollment is not met. Synergy Petaluma reserves the right to close facilities for maintenance, change rooms for best utilization, modify fees or substitute teachers when necessary.

FOR OFFICE USE ONLY

PAYMENT INFORMATION (MUST BE COMPLETED)

❑ Check enclosed ❑ Visa ❑ MasterCard _____ Card Number _____/_____/_____ Exp. Date

_____ Account Holder Name / _____ Account Holder Signature _____ Date

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ADMINISTRATION OF MEDICATION WAIVER

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1. MEDICATION

I, _____ give permission to _____
Parent/Guardian Name — Name of Caregiver

to give my child _____ the following medicine _____
Name of Child — Name of Medicine

for _____ on _____
Problem or Illness — Date or Dates

at _____ in the amount of _____
Time or Times — Amount or Amounts

by _____
Body Location and Method of Use

side effects of the medicine to watch for _____
Possible Side Effect

this medicine has been prescribed by _____
Name of Doctor

the telephone number of the doctor is _____
Phone Number — Additional Contact Information

_____
Parent/Guardian Signature — Date

2. MEDICATION

I, _____ give permission to _____
Parent/Guardian Name — Name of Caregiver

to give my child _____ the following medicine _____
Name of Child — Name of Medicine

for _____ on _____
Problem or Illness — Date or Dates

at _____ in the amount of _____
Time or Times — Amount or Amounts

by _____
Body Location and Method of Use

side effects of the medicine to watch for _____
Possible Side Effect

this medicine has been prescribed by _____
Name of Doctor

the telephone number of the doctor is _____
Phone Number — Additional Contact Information

_____
Parent/Guardian Signature — Date

3. MEDICATION

I, _____ give permission to _____
Parent/Guardian Name — Name of Caregiver

to give my child _____ the following medicine _____
Name of Child — Name of Medicine

for _____ on _____
Problem or Illness — Date or Dates

at _____ in the amount of _____
Time or Times — Amount or Amounts

by _____
Body Location and Method of Use

side effects of the medicine to watch for _____
Possible Side Effect

this medicine has been prescribed by _____
Name of Doctor

the telephone number of the doctor is _____
Phone Number — Additional Contact Information

_____
Parent/Guardian Signature — Date