

CAMP OAKES

CAMPER'S NAME		DATE OF BIDTH	AGE		CDADE post school year		
CAMPER 5 NAME		DATE OF BIRTH	AGE	į	GRADE next school year	MALE	
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CAMPER'S HOME ADDRESS				HOME PHONE	<u> </u>	FEIVIALE	
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CAMPER'S EMAIL ADDRESS				+			
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	TARENT/CII/	TELEVISION OF LIBROR			THE TOTAL PRIVATE HEAD IN THE TENT	TO LEADERS	
PARENT/GUARDIAN #1	PAREN1/00A	ARDIAN #1 CELL PHON	Ē	ļ	PARENT/GUARDIAN #1 EMA	AIL ADDRESS	
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TO DESTRUCTION OF THE PROPERTY	DADENT/GII/	. 22.471 #1 MOBA BHC			BASENT/CHARDIAN #1 DAT	T OF BIRTH	
PARENT/GUARDIAN #1 EMPLOYER	PAREN1/00A	ARDIAN #1 WORK PHO	NE	ļ	PARENT/GUARDIAN #1 DAT	E OF BIRTH	
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	2. DENT/GII/	יים איים מיים איים מיים איים איים איים א			TOTAL CLARDIAN #2 EM		
PARENT/GUARDIAN #2	PAREN1/00A	ARDIAN #2 CELL PHON	Ē	ļ	PARENT/GUARDIAN #2 EMA	AIT ADDKE22	
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PARENT/GUARDIAN #2 EMPLOYER	DADENT/GII/	ייייי איי אייטטע פאר פאר			BASENT/CHARDIAN #2 DAT	T OF BIRTH	
PARENT/GUARDIAN #2 EMPLOYER	PAREN I/UUA	PARENT/GUARDIAN #2 WORK PHONE		į	PARENT/GUARDIAN #2 DAT	E OF BIRTH	
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EMERGENCY CONTACT #1	HOME BHOK	IS (SELL PHONE			WORK PHONE/OTHER		
EMERGENCY CONTACT #1	HOME PHONE/CELL PHONE		i	WURK PHUNE/UTHER	ĺ		
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EMERGENCY CONTACT #2	HOME PHONE	NE/CELL PHONE		ļ	WORK PHONE/OTHER	ĺ	
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EMERGENCY CONTACT #3	HOME PHONE	NE/CELL PHONE		į	WORK PHONE/OTHER	ĺ	
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ALLERGIES OR IMPORTANT MEDICAL HISTORY (please be spe	ecific seizures	s, allergies to food, dr	ugs, bees)				
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PLEASE LIST ANY OTHER INFORMATION IMPORTANT FOR THE CAMP STAFF (dietary needs, sleepwalking, bedwetting, ADD, autism, fears, worries, etc)							



JUNE 18-25, 2016

I HEREBY CERTIFY THAT	IS IN GOOD PHYSICAL CONDITION WHICH WILL ALLOW						
HIM OR HER TO PARTICIPATE IN NORMAL CAMP ACTIVITIES.							
I ALSO HEREBY CERTIFY THAT THE ABOVE LISTED CAMPER IS FREE FROM ANY COMMUNICABLE DISEASES WHICH MIGHT BE TRANSMITTED							
TO OTHER CAMPERS DURING HIS OR HER STAY AT CAMP.							
PARENT/GUARDIAN SIGNATURE	DATE						
INCURANCE INCORMATION (Asserts arranged white forms Madi Calabidous etc.)							
INSURANCE INFORMATION (Attach emergency claim forms, Medi-Cal sticker, etc if necessary)							
FAMILY MEDICAL/HOSPITAL INSURANCE:							
CARRIER: POLICY OR GROUP #							
EMPLOYER							
positive guidance within their first 90 (ninety) days of employment. As part of our policies on members/participants outside of YMCA programs. <i>Please do not put staff in a difficult positic any other outside events.</i>	on by asking them to provide personal childcare or engage in						
PARENT/GUARDIAN SIGNATURE	DATE						
I, the undersigned parent/guardian having legal custody of the above said minor, give permission for the minor to participate in the program described above. The minor is physically able and mentally prepared to participate in all activities as described in the announcement for the program. I, on behalf of myself (as parent, guardian, or participant) hereby: 1. Acknowledge that (i) I have read this document, (ii) I have inspected the YMCA facilities and equipment, (iii) I accept them as being safe and reasonably suited for the purposes intended and (iv) I voluntarily sign this document. 2. Release the YMCA, its directors, officers, employees and volunteers (collectively "Releasees") from all liability to me for any loss or damage to property or injury or death to person, whether caused by Releasees or otherwise and while such minor is in or near the YMCA. 3. I agree not to sue Releasees for any loss, damage, injury or death described above and I will indemnify and hold harmless Releasees and each of them from any loss, liability, damage or cost they may incur due to said minor's presence in, upon or near the YMCA's branch; whether caused by the negligence of Releasees or otherwise.							
4. I assume full responsibility for, and risk of, bodily injury, death or property damage due to the negligence of Releasees or otherwise. 5. I do hereby authorize the YMCA as agent for the undersigned, to consent with respect to said minor, to any x-ray examination, anesthetic, medical, dental, or surgical diagnosis or treatment, and hospital care which is deemed advisable by and is to rendered under general or special supervision of, any physician and surgeon licensed under the provisions of the California Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of the physician or at the hospital. I understand that the YMCA is not responsible for costs incurred for medical care. PHOTO RELEASE: I give my permission to the Family YMCA of the Desert to use my child's picture or other likeness in any of the YMCA's general publicity and campaign materials.							