

Cutting Edge Martial Arts

2018 Summer Camp Registration Form

This form and a \$95 deposit is due the week before the camp session starts with the \$100 balance (\$200 Teen) due the first day of camp. As camp time approaches, you will be emailed a daily camp schedule and a list of what your child will need. Camp will be held at Cutting Edge Martial Arts, 215 Haggerty Lane, Bozeman. Multiple family members, multiple sessions, and early registration applies a \$5 discount on the \$100 balance. All discounts may be applied.

Camp sessions: Session I – June 18-22nd, Session II – July 9th-13th, Session III – Aug. 6-10th, Teen Aug. 13-17th.

Camp times: 9am-1pm Monday-Friday, 9am-7pm Wednesday. Teen 9am-5pm Monday-Friday.

Camper's name: _____ Date: _____

Camper's age at time of camp: _____ Camper's date of birth: _____ Sex: M F

Name of parent or guardian: _____ Sessions camper will attend: I II III T

Address: _____ Home phone: _____

Email: _____ Work phone: _____

If not the above, whom should we contact in case of emergency? _____

Relation of contact to camper: _____ Emergency phone: _____

School camper attends: _____ Going into which grade? _____

If camper has prior experience in martial arts, what rank? _____

If camper is not a student of our school, how did you hear about it? _____

Is there anything else you would like us to know about your child? _____

Does your child have any of the following allergies?

Hay fever Bee stings Insect bites Penicillin Peanuts Other _____

Has your child had any of the following?

Chicken pox Tuberculosis Epilepsy Hepatitis Mononucleosis

Other(including heart or lung conditions or any other chronic or recurring illness) _____

Does your child have asthma? Y N Does your child wear glasses or contacts? Y N

Is your child taking any medication? Y N If yes, please list medications and reason: _____

I hereby give permission for Cutting Edge Martial Arts to dispense prescribed medications to my child.

Parent or guardian's name: _____ Signature and date: _____

Has your child ever been hospitalized? If so, please indicate when and for what reasons: _____

Local doctor's name: _____ Phone: _____

I hereby swear that all the foregoing information is true and correct to the best of my knowledge.

Parent or guardian's name: _____ Signature and date: _____

In the event that my child needs immediate medical care and neither parent nor the child's local doctor is available, I authorize Cutting Edge Martial Arts to seek emergency treatment at Bozeman Deaconess Hospital and to have a doctor or nurse administer necessary medical treatment and/or to have necessary X-rays taken for emergency care.

Parent or guardian name: _____ Signature and date: _____

Insurance company: _____

Policy number: _____

Insurance Phone: _____ Claimant's name: _____

Claimant's signature and date (for care): _____

Drop off at CEMA, 215 Haggerty Lane OR Mail to: Mark Austin, 307 Helen Dr., Belgrade, MT 59714