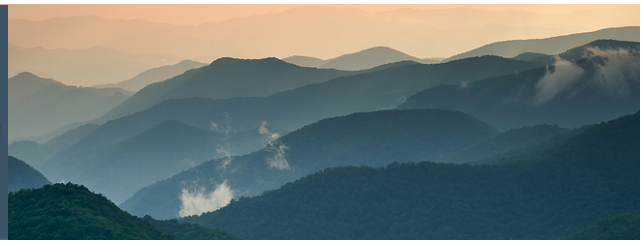

DAY CAMP ENROLLMENT FORM

Day Camp Times and Options

Visions USA, LLC
Asheville, NC 28806
Phone: (828) 989-7021 • Mail: info@visionsusa.org

Family Name

First Name | Middle Name

Gender Male ☐ Female ☐ | Date of Birth (Year) (Year) (Year)

Week	Dates	Excursion*	Price*
Week 1	6/29 to 7/2 — no day camp 7/3	*Chimney Rock & Picnic at Lake Lure*	$225
Week 2	7/6 to 7/10	*White Water Rafting*	$225
Week 3	7/13 to 7/17	*Asheville Tourists Game*	$190
Week 4	7/20 to 7/24	*Carowinds*	$250
Week 5	7/27 to 7/31	*Chimney Rock & Picnic at Lake Lure*	$225
Week 6	8/3 to 8/7	*Green River Tubing*	$190
Week 7	8/10 to 8/14	*Carowinds*	$250

Host Families

☐ Yes ☐ No

Are you hosting, and if so, are you planning on taking advantage of our one week free tuition for your own child?

If so, please indicate which week. #

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DAY CAMP ENROLLMENT FORM
Student Information

Home Address

Parent Name

Best Contact Email Best Parent Phone #

Emergency Contact Persons' Information

Name 1 Phone

Name 2 Phone

Health Information Student

Does your child suffer from any allergies? ☐ Yes ☐ No
If yes, please specify and describe the severity and treatments.

Does your child follow a special diet? *If so, please explain.* ☐ Yes ☐ No

Has your child ever been hospitalized? *If yes, please explain.* ☐ Yes ☐ No

Please indicate any other pertiinent medical information and/or conditions; ex. ADHD, anxieties, seizures.

Please indicate any medications your child is taking currently and their purpose.

Does your child administer their own medication? Yes No

Please name any prescriptive/nonprescriptive drug(s) that should not be administered by your child.

Date of last Tetanus injection/booster:

Is your child a proficient swimmer? *If no, please elaborate.* ☐ Yes ☐ No

Are their any activities your child should not participate in for medical or general health reasons?

VISIONSUSA

DAY CAMP ENROLLMENT FORM
Miscellaneous Information

Name of Health Insurance Company

Insurance Card #

Diet

Does your child follow a special diet? ☐ Yes ☐ No If yes, please explain.

Does your child suffer from any food-related allergies? ☐ Yes ☐ No If yes, please elaborate.

Medical Treatment Authorization and Consent

In case of any emergency related to your child, we will notify you immediately. A qualified staff member will administer first aid treatment. We ask you to read and sign the following.

I, _____ , the parent/guardian of _____ hereby authorize, seek and consent to medical treatment as deemed necessary by a qualified licensed First Aid representative of Visions USA, LLC or medical and healthcare professional. This authorization is for the time period when my child is in the care of Visions USA, LLC and while his/her participation in the organization's programming.

In the event that my child should require medical care or treatment, I agree to be financially responsible for any costs incurred as a result for such treatment. I am aware and understand that I should carry my own health insurance for my child.

Signature of Parent/Guardian _____ Date Month ____ Day ____ Year ____

Accident Waiver and Liability Release

As parent/guardian, I hereby assume all the risk of a participation in the Visions USA, LLC program for myself and my child/ren. I will not hold Visions USA, LLC liable for any bodily injury or loss of personal valuables, unless damage occurs as a result of a Visions USA, LLC representative's willful actions, neglect or recklessness.

Signature of Parent/Guardian _____ Date Month ____ Day ____ Year ____

Do you grant Visions USA permission to take and publish photos of your child for marketing purposes? ☐ Yes ☐ No

Upon completion, please send this application via scanned email attachment to *info@visionsusa.org* or mail it to the Visions USA office. We will send you a confirmation and invoice upon receipt.