

MILFORD COMMUNITY SCHOOL USE PROGRAM

February or April Vacation Kids Kamp – Full Day (Grades K – 8)
February or April Vacation Kamp – Half Day (Grades 5 – 8 only)

NAME:		GRADE:
CIRCLE: FEMALE MALE	HOME PHONE:	CIRCLE: Gr K-8 Gr 5 - 8 Full Day Half Day
ADDRESS:		
FATHER'S NAME:	WORK PHONE:	
	CELL PHONE:	
MOTHER'S NAME:	WORK PHONE:	
	CELL PHONE:	

EMAIL ADDRESS _____ @ _____

Is your child currently enrolled in the EXTENDED DAY PROGRAM? YES _____ NO _____

OTHER EMERGENCY CONTACTS (other than parents): ****MUST HAVE AT LEAST ONE****

NAME:	PHONE:
	PHONE:
NAME:	PHONE:
	PHONE:

Does your child have any handicaps, physical or emotional, or allergies, which the Milford Community Program should be aware of? (please list and explain)

In case of emergency, and we are unable to reach you or your physician, may we send your child to Milford Regional Medical Center for emergency treatment? YES _____ NO _____

I, the undersigned, as parent/guardian of _____, a minor child, do hereby permit Milford Regional Medical Center and its physicians to perform on this child any procedure or treatment as may be deemed necessary in an emergency situation.

DATE _____ SIGNATURE _____

I do ___ do not ___ consent and authorize the Milford Community Program to use and reproduce photographs taken of my child for advertising and publicity purposes.

DATE _____ SIGNATURE _____

I/We the parent(s)/guardian(s) of _____, a participant in KIDS KAMP, hereby give my/our approval to his/her participation in any and all Milford Community School Use Program activities during the current year. I/We assume all risks and hazards incidental to such participation, including transportation to and from the activities; and I/We do hereby waive, release, absolve, indemnify and agree to hold harmless the Milford Community School Use Program, the town of Milford, the organizers, supervisors, sponsors, participants, and persons transporting my/our child to or from activities, for any claim arising out of an injury to my/our child to the extent covered by accident or liability insurance.

DATE _____ SIGNATURE _____