# Summer Rec 2017

**Grades K-6 Children must be 5 years old on or before June 23, 2017**

**Forms received after 6pm Thursday the week prior to the camp are subject to a $10 late fee.**
**Payment in full is due at registration. No refunds.**

Child's Name: _____ DOB: _____ Age: _____ Sex: M F

Allergies/Special Needs: _____

Parent/Guardian's Name: _____

Phone: (w)_____ (h)_____ (c)_____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Emergency Contact: _____ Phone: _____

Please select: ____ HQ Member ____ Non Member

**Please check weeks needed: ($60.00 per week per child)** **Monday – Thursday 9am – 12pm**

____ Wk 1 - June 19-22 ____ Wk 2 - June 26-29 ____ Wk 3 - July 3-7 (no camp 7/4) ____ Wk 4 - July 10-13

____ Wk 5 - July 17-20 ____ Wk 6 - July 24-27 ____ Wk 7- July 31-Aug 3 ____ Wk 8 - Aug 7-10

____ Wk 9 - Aug 14-17 ____ Wk 10 - Aug 21-24 ____ Wk 11 - Aug 28-31

Total Balance Due: $_____

**RELEASE STATEMENT:**
I, the parent/guardian of the registrant, a minor, or an adult registrant of legal age, agree that the registrant and I will abide by the rules of HealthQuest, its affiliated organization and sponsors. Recognizing the possibility of physical injury associated with leagues and in consideration for HealthQuest accepting the registrant for its league programs and activities, I hereby release, discharge, and/or otherwise indemnify HealthQuest, its officers, coaches, managers, referees, its affiliated organizations and sponsors, their employees, and associated personnel, including the owners of the fields and facilities utilized for the league program, against any claim by or on behalf of the registrant as a result of the registrant's actions. I affirm that the registrant is in sound physical and healthy condition and that the athlete is covered by health/accident insurance secured independently. As parent/guardian or the registrant, I hereby give my permission for the participant of the program to be transported for emergency medical care. I hereby authorize consent for emergency medical care prescribed by a duly licensed Doctor or Medicine or Doctor of Dentistry. This care may be given under whatever conditions necessary to preserve life, limb or well being of my dependent.

Parent's Signature: _____ Date: _____

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**Method of Payment:**

- ☐ Cash
- ☐ Check #_____
- ☐ Charge to HQ Account – Scan Card #_____
- ☐ Credit Card – Circle One: Amex Discover MasterCard Visa

Card Number: _____ Exp Date: _____

Customer Signature: _____ Date: _____

*Signature required for all HQ Member Account charges & Credit Card Transactions