Super Kid Academy

2008-2009

Make Check Payable to "Mt. Olive Recreation" and send form to:
Mt. Olive Township
Recreation Department
PO Box 450
Budd Lake NJ 07828

1st child's name ________________________________ Age ______

Class: {□ Tues & Thurs a.m. classes} {□ Tues & Thurs p.m. classes}
{□ Mon, Wed, & Fri a.m. Classes} {□ Mon, Wed, & Fri p.m. Classes}

1st Contact

Emergency Contact Name: ____________________________________Phone: ( ) _______ - __________

Emergency Contact Address:___________________________________ City:______________ Zip:________

2nd Contact

Emergency Contact Name: ____________________________________Phone: ( ) _______ - __________

Emergency Contact Address:___________________________________ City:______________ Zip:________

2nd child's name ________________________________ Age ______

Class: {□ Tues & Thurs classes} {□ Mon, Wed, & Fri a.m. Classes} {□ Mon, Wed, & Fri p.m. Classes}

1st Contact

Emergency Contact Name: ____________________________________Phone: ( ) _______ - __________

Emergency Contact Address:___________________________________ City:______________ Zip:________

2nd Contact

Emergency Contact Name: ____________________________________Phone: ( ) _______ - __________

Emergency Contact Address:___________________________________ City:______________ Zip:________

Parents or Guardian:____

Address:____ Phone: ( ) _______ - __________

City:_______________________ State:_________ Zip:___________________

e-mail address _____________________________@_______________ **(E-mail address is now Required!)**

A non-refundable payment of $25 must be made at time of registration.

A payment schedule will follow. All late payments will be charged a $20 late fee.

As in any activity, there are inherent risks and injuries that may occur. I hereby release and discharge the Township of Mt. Olive, its agents, employees, appointed officials, volunteers, commissions, or associations from any and all actions for losses, damages, or personal injuries to myself or my child which may occur or arise out of my or my child's participation in the above activity. You will be called if there is a change in schedule. Your cancelled check will serve as your receipt. **Checks returned for insufficient funds will require an additional $20 processing fee, in addition to cash or money payment for the program.**

Parent/Guardian Signature ___________________________________ Date: _____ / _____ / _____

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Authorization for Emergency Medical Treatment of Minors

1st Child's Name:______________________________________ DOB:_______________

Date of Last Tetanus Immunization:____

Pertinent Medical History or Chronic Illness, Allergies and Medication:____________________

____

2nd Child's Name:______________________________________ DOB:_______________

Date of Last Tetanus Immunization:____

Pertinent Medical History or Chronic Illness, Allergies and Medication:____________________

Pediatrician or Primary Care Physician (child's):____

Other Medical Specialists:____

Medical Insurance Name:____

Group #:______________________________________

ID #:______________________________________

******* A photocopy of your insurance card is required! *******

We, the undersigned, and parent(s) or legal guardian(s) of the above minor(s) do herby authorize Super Kid Academy, it's employees, volunteers, and affiliates to whom we have entrusted the care of these minor(s) from September 2008 to June 2009, consent to any necessary emergency medical or surgical treatment, anesthesia, or any required diagnostic tests, in the event that I (we) cannot be contacted.

Parent/Guardian Signature __________________________________ Date: _____ / _____ / _____