CHAP Summer Day Camp Registration Form **Camper Name: _____ Age: ____**
Dates child will attend ____ July 9th – July 27th ____ July 30th – August 17th

Child

First _____ Middle _____ Last _____ Gender: Male __ Female__
Birth date _____/_____/_____
Street Address _____
Town/City _____ State _____ Zip code _____ Child's Home Phone _____

Parent/Guardian - Contact Information

Parent/Guardian #1

First_____Last_____ Ms. Mrs. Mr. Other _____
Street Address _____
Town/City _____ State ___ Zip Code _____ Home Phone _____ Work Phone _____
Cell phone _____ E-mail _____

Parent/Guardian #2

First_____Last_____ Ms. Mrs. Mr. Other _____
Street Address_____
Town/City _____ State ___ Zip code _____ Home Phone _____ Daytime phone _____
Cell phone _____ E-mail _____

Child lives with: _____

Emergency Contact Information – Alternate Pickup/Release

Emergency Contact #1

First Name _____ Last Name _____ Home Phone _____ Work Phone _____
Cell Phone _____ Email _____ Relation to child _____
Permitted to pick up: YES __ NO__

Emergency Contact #2

First Name _____ Last Name _____ Home Phone _____ Work Phone _____
Cell Phone _____ Email _____ Relation to child _____
Permitted to pick up: YES __ NO__

Medical Release Information

Insurance Information
Policy Number_____ Name of Health Insurance Provider_____
Primary Physician_____
Address_____
Phone_____ Hospital Preference_____

Please list any medical problems, including any requiring maintenance medication (i.e. Diabetic, Asthma, Seizures).

Medical Problem	Required treatment
_____	_____
_____	_____
_____	_____

Please list all medications and dosages your child is currently taking. (including an EpiPen)

Medication	Dosage
_____	_____
_____	_____
_____	_____

Is your child allergic to any type of food or medication?
Yes__ No__ If yes, explain:_____

Parent - Provider Transportation Agreement

CHAP SUMMER CAMP

I, _____, give permission for the CHAP summer camp staff, or any approved
(Name of parent)

employee of the above program, to transport my child _____
(Name(s) of child)

for the following reasons (check all that apply):

_____X_____ Field trips

It is agreed that:

1. My child will not be left unattended in any motor vehicle or other form of transportation.
2. Each child will board or leave a vehicle from the curb side of the street.
3. My child will be secured in safety seats or by safety belts as appropriate for the age of the child in accordance with the law.
4. Any motor vehicle used to transport my child will have current registration and inspection stickers, and must be operated by a person who is at least 18 years of age and possesses a valid driver's license.
5. All parents will notified in advance of any instance where my child will be transported while in care.

_____ _____
(Parent or Guardian) (Date)

_____ _____
(Provider/Director) (Date)

FREE!

Thanks to

Funding from:

Children's Hope Initiative

Ages 9-13

Who have experienced challenges due to abuse/neglect/trauma

Summer day CAMP

Session 1

July 9th – July 27th

Session 2

July 30th – August 17th

Monday, Wednesday, & Friday

9am-3pm

Richard Hall CMHC

500 North Bridge Street
Bridgewater, NJ 08807

Registration: Immediately!

Contact:

Naomi Persaud: 908-253-3167

- Yoga
- Meditation
- Art
- Music
- Physical - Conditioning
- Karate
- Equine Assisted Therapy

SPRNG REINS of LIFE 501c3

Horses, Humans & Healing

Release of Liability

Read the following General Statement before signing:

Participating in activities with horses involves an inherent risk including the risk of serious injury or death. I agree to take part in this therapy session /workshop /demonstration on the understanding that I will take responsibility for my own safety and that being around horses entails known and unanticipated risks that could result in injury or death to others or me. I hereby assume all risks in connection therewith and expressly waive any claims for injury or loss arising there from.

To the extent permitted by law, I hereby agree to protect, indemnify, defend, and hold harmless **Spring Reins of Life, 501c3 ("SRoL")**, the **SRoL** Board and Committees, and all **SRoL** Employees, Agents, Directors, Associates, Affiliates, Contract Personnel, the Hosting Facility and all Owners, Managers, Volunteers, Employees, and persons involved with the host facility, and all the Participants in the therapy sessions / workshops / demonstrations against all claims/losses arising out of participation in this equine assisted experience. For all EAP/EAL sessions on premises of Hunt Cap Farms / 401 Main Street, Three Bridges, NJ 08887.

Date: _____ **Name:** _____ **Signature:** _____

Address: _____ **Email:** _____

Age (if minor): _____ **Name of Parent(s)/Guardian if Minor:** _____

Signature of Parent/Guardian if Minor: _____ **Phone:** _____

SRoL Release to Use Image

I, the undersigned, hereby grant *Spring Reins of Life – Horses, Humans & Healing, 501c3* ("**SRoL**") permission to use, adapt, modify, reproduce, distribute, publicly perform and display, in any form now known or later developed, my image or visual likeness (the "Personal Information") throughout the world, by incorporating it or them into publications, catalogues, brochures, books, magazines, photo exhibits, advertising, or promotional materials relating thereto.

I release, and hereby agree to indemnify, defend, and save harmless **SRoL**, its agents, employees, licensees and assigns (collectively "Released Entities") from any and all claims I, or any third party, may have now or in the future for invasion of privacy, right of publicity, copyright infringement, defamation or any other cause of action arising out of the use, exploitation, reproduction, adaptation, distribution, broadcast, performance or display of the Personal Information.

I waive any right in inspect or approve any Works that may be created using the Personal Information and waive any claim with respect to the eventual us to which the Personal Information may be applied. The Personal Information may be used at **SRoL**'s sole discretion, alone or in conjunction with any other material of any kind or nature except that **SRoL** will not use the Personal Information for any criminal or illegal purposes or in a manner inconsistent with community standards of decency.

I understand and agree that **SRoL** is and shall be the exclusive owner of all right, title, and interest, including copyright, inn the Works, and any commercial, informational, educational, advertising, or promotional materials containing the Materials. I also understand that I (or my child) will not receive payment for any use of the Personal Information. I am of full legal age and have read this release and am fully familiar with its contents. By their signature below, a minor's parent(s) or legal guardian(s) indicate, on behalf of their minor child, their full and unqualified consent to the terms of this Release of Image. (*If participant is a minor, parent/guardian signs release of image use for participant listed above).

Date: _____ **Name:** _____ **Signature:** _____

Medical Clearance Form

Dear Doctor:

Your patient _____ wishes to take part in a summer camp which will include an exercise program and/or fitness assessment. The exercise program may include progressive resistance training, flexibility exercises, and a cardiovascular program; increasing in duration and intensity over time. The fitness assessment may include a sub-maximal cardiovascular fitness test and measurements of body composition, flexibility, and muscular strength and endurance.

After completing a readiness questionnaire and discussing their medical condition(s) we agreed to seek your advise in setting limitations to their program. By completing this form, you are not assuming any responsibility for our exercise and assessment program. Please identify any recommendations or restrictions for your patient's fitness program below (Physician's Recommendations).

Patient's Consent and Authorization

I consent to and authorize _____ to release to _Richard Hall CMHC health information concerning my ability to participate in an exercise program and/or fitness assessment. I understand this consent is revocable except to the extent action has already been taken. Authorization is not valid beyond one year from date of signature. Further disclosure or release of my health information is prohibited without specific written consent of person to whom it pertains.

Patient name	Date
Guardian signature	

Physician's Recommendations

	I am not aware of any contraindications toward participation in a fitness program.
	I believe the applicant can participate, but urge caution because:
	The applicant should not engage in the following activities:
	I recommend the applicant **not** participate in the above fitness program.

Physician's signature		Date
Physician's name (print)	Phone	Fax
Address	City	State & Zip

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Dates child will attend ____ July 9th – July 27th ____ July 30th – August 17th

Does your child require a special diet?
Yes__ No__ If yes, explain:_____
The purpose of the above listed information is to ensure that medical personnel have details of any medical problem which may interfere with or alter treatment.

In case of medical emergency contact:

	Name	Phone #	Relationship to Child
Contact #1			
Contact #2			
Contact #3			

I understand that I will be notified in the case of a medical emergency involving my child. In the event that I cannot be reached, I authorize the calling of a doctor and the providing of necessary medical services in the event my child is injured or becomes ill.

Parent's/Guardian's Initials _____

I understand that the Richard Hall Community Mental Health Center will not be responsible for the medical expenses incurred, but that such expenses will be my responsibility as parent/guardian.

Parent's/Guardian's Initials _____

Terms of Agreement

Photo Release

I hereby give permission for my child to be photographed during the CHAP Summery Day Camp. I understand the photos will be used to keep a journal of activities and to report to our donors. I understand that do not expect compensation and all photos are the property of the CHAP Summer Day Camp and its affiliates.

Parent's/Guardian's Initials _____

The CHAP Summery Day Camp and its co-organizers are not responsible for lost or damaged personal property. All scheduled events are subject to change. Children's' photos and quotes may be used for publicity purposes. In case of an emergency, and if a family physician cannot be reached, I hereby authorize my child to be treated by Certified Emergency Personnel (i.e. EMT, First Responder, and/or Physician).

Guardian Signature: _____ Date: _____

Printed Name of Parent/Guardian: _____