

SUMMER CAMP 2011 APPLICATION FORM

All Art Camp - Art Institute of Weston

CAMPER'S NAME:	Attended our camp before: [] Yes [] No
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Address:

City:	State:	Zip code:
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Camper's Birthday: / /	Age:	Sex:
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PARENTS

Home phone:	Work Phone:
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Mother's Name:	Father's Name:
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Mother's Cellular:	Father's Cellular:
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Mother's email:	Father's email:
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CAMPS HOURS

(Select) **9:00AM to 3:00 PM** (Select)

Session ONE		(June 14 to June 18)		Session SIX		July 19 to July 23
Session TWO		(June 21 to June 25)		Session SEVEN		July 26 to July 30
Session THREE		(June 28 to July 2)		Session EIGHT		August 2 to August 6
Session FOUR		(July 5 to July 9)		Session NINE		August 9 to August 13
Session FIVE		(July 12 to July 16)				

- Regular Camp (1week): Hours (9:00am to 3:00pm)
- Camp tuition: \$235.00 (including all materials and snacks)
- A one-week deposit must be paid to guarantee space.
- **NO REGISTRATION FEE**

EXTENDED HOURS

<input type="checkbox"/> 8:00am to 3:00pm	add. \$15.00 per week
<input type="checkbox"/> 8:00am to 4:00pm	add. \$30.00 per week
<input type="checkbox"/> 9:00am to 4:00pm	add. \$15.00 per week
<input type="checkbox"/> 9:00am to 5:00pm	add. \$30.00 per week

NO REFUND AND OR MAKE-UP CLASSES

Campers must bring their own lunches, clearly marked with their name. Free snacks will be provided at the end of each session.

Any medical problems:

(Explain here)

I hereby give permission to the **ART INSTITUTE OF WESTON** and/or its designee to ensure that medical intervention/treatment of my child is given by Emergency personnel to ensure that my child receives the proper medical treatment, under provision of the **Medical Practice Act**; in my absence should an injury occur. I understand that due to insurance regulations, paramedics or ambulance must transport injured or ill children to a Hospital, where necessary. **CAMP PERSONNEL CANNOT TRANSPORT THEM.** It is also my intent to grant authority to administer and perform any and all examinations including but not limited to x-ray examinations, treatment, anesthetics, and diagnostic procedures that may in the course of my child's care be deemed advisable and necessary. I also understand and agree that I will be responsible to pay any and all charges incurred as a result of my child's treatment at the treating Hospital and/ or expense for transportation to a Hospital.

Please, list all individuals (including parents) allowed to pick up child:

1- Name:	Relationship:
2- Name:	Relationship:
3- Name:	Relationship:
4- Name:	Relationship:

I _____ hereby grant permission to the Art Institute of Weston to use photos, video tapes, DVD, or any other record of classes, programs, or artwork for any purpose.

I HAVE READ AND UNDERSTAND THE ABOVE POLICY, and agreed to all the rules and regulations of the Institute:

Name:	Date:
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Signature: (sign here)

Approved by:

PAYMENT:

To make your payment **by check**, please mail to:
Art Institute of Weston, Suite 1600, 2900 Glades Circle, Weston, FL 33327

❖ To make your payment **by credit card**, please fill out the following information:

Name:	First:	Last:
Credit Card Number:		
Expiration date:	Month:	Year:
3 digits from the back of the card:		
Your signature:		

Fax this form to fax # **954-659-2441**

Or deliver it in person to:

Art Institute of Weston, Suite 1600, 2900 Glades Circle, Weston, FL 33327