

# SUMMER CAMP 2009 APPLICATION FORM

All Art Camp – Atlanta/Buford

CAMPER'S NAME:	Attended our camp before: <input type="checkbox"/> Yes <input type="checkbox"/> 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				Session SIX		
Session TWO				Session SEVEN		
Session THREE				Session EIGHT		
Session FOUR				Session NINE		
Session FIVE						

- Regular Camp (1 week): Hours (9:00am to 3:00pm)
- First week of camp \$220.00 (including all materials and snacks)
- Second week and there after you will receive a discount:
  - Cost per week \$195.00 (including all materials and snacks)
- A one-week deposit must be paid to guarantee space.
- One Week Camp: \$220.00
- **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)

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I hereby give permission to the Early Art Education Institute 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 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:  
  
Early Art Education Institute, Suite Mall of Georgia, 3480 Financial Center Way, Suite 1060  
Buford, GA 30519

✓ 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: **770-831-6298**  
Or deliver it in person to: Early Art Education Institute  
The Mall of Georgia, 3480 Financial Center Way, Suite 1060 (next to Toys"R"Us)  
Buford, GA 30519