

# WAYNE EDUCATION FOUNDATION

## 2017 Summer Camp Registration Form

*Please complete one form for each camper.*

Camper Name: \_\_\_\_\_ School/Grade 2017-2018: \_\_\_\_\_

Address: \_\_\_\_\_

Parent Name(s): \_\_\_\_\_ Parent Home: \_\_\_\_\_

Parent 1 Cell: \_\_\_\_\_ Parent 2/Alternate No: \_\_\_\_\_

Email Address (PLEASE PRINT CLEARLY): \_\_\_\_\_

Please indicate camp(s) choices below:

Camp Name	Dates	Time	Fee

**PLEASE LIST ANY FOOD ALLERGIES OR GENERAL HEALTH INFORMATION WE NEED TO KNOW ABOUT YOUR CAMPER:**

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**Parent(s) and Camper Participation Agreements (Please Circle Y or N):**

- Y N I understand I may not leave my camper(s) unless a staff member is present at the facility.
- Y N I understand my camper will need transportation promptly at each end of day session.
- Y N I understand my camper may be removed from the WEF Camp for inappropriate behavior or behavior that endangers themselves or others.
- Y N I understand the \*Refund Policy Guidelines as stated below.
- Y N I give consent for staff to photograph my camper with the understanding that my camper's image may be used by the WEF for promotional materials, including the WEF website, social media and local news media.
- Y N I understand in the event the camps I have listed above are closed at the time of receipt of my registration form, the WEF will contact me to discuss alternative camp offerings.

**\*Refund Policy Guidelines:**

Refund requests must be submitted in writing by emailing [wayneeducationfoundation@gmail.com](mailto:wayneeducationfoundation@gmail.com) fifteen (15) business days prior to the first day of camp. The refund processing fee is \$10.00. Fees will not be prorated for late enrollment, missed classes or non-attendance.

**Medical Treatment Acknowledgement and Guidelines:**

I have no knowledge of any physical impairment that could adversely affect my child's health or wellbeing when participating in this camp. I hereby grant permission for my child to be given first aid by the Camp Director or Athletic Trainer or Staff Member. In the event of an emergency, in which my child requires medical care, I grant permission for my child to be provided with emergency medical treatment. I will be responsible for any medical or other charges in connection with my child's attendance in this camp.

**Acknowledgement:** I have read, understand and agree to the Agreements stated above.

Parent Signature (REQUIRED): \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE MAKE ALL CHECKS PAYABLE TO: WAYNE EDUCATION FOUNDATION**

Mail in or drop off Registration Form and payment to:

Wayne Education Foundation  
c/o Summer Camp Director  
75 Urban Club Rd, Wayne, NJ 07470

**Please direct all questions via email to [wayneeducationfoundation@gmail.com](mailto:wayneeducationfoundation@gmail.com) or call/text 862-248-2847.**