

CAMP SONRISE MOUNTAIN APPLICATION

Arctic Blast

Feb. 3<sup>rd</sup>-Feb. 5<sup>th</sup> 2017

**Deadline for Application: January 29<sup>th</sup>**

COST: \$55

Registration: Friday, February 3<sup>rd</sup> @ 6pm

Pick up: Sunday, February 5<sup>th</sup> @ 1pm

For Grades 6 – Graduating Seniors

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**Camper Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

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

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Preferred Phone #:** (\_\_\_\_\_) \_\_\_\_\_

**Alternate Phone #:** (\_\_\_\_\_) \_\_\_\_\_

**Parent Email Address:** \_\_\_\_\_

**Local Church:** \_\_\_\_\_

.....  
**Medical Information:**

**Physician Name:** \_\_\_\_\_ **Phone #:** (\_\_\_\_\_) \_\_\_\_\_

**Allergies:** \_\_\_\_\_

\_\_\_\_\_  
**Medications:** \_\_\_\_\_

\_\_\_\_\_  
.....

I release the camp management and staff in charge from all responsibility of illness and accident occurring during my child’s stay at camp. I give the camp staff permission to have my treated at a medical facility in case of needed emergency treatment, in which case 911 will be called. I will accept any charges incurred that are not covered by insurance. I give the camp staff permission to give my child non-prescription medication if needed.

**Parent’s Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Please make check payable to: ARCM**

**Mail application and payment to:**

**Becky Rodriguez**

**620 Wesley Chapel Rd.**

**Scottsdale, PA 15683**

**Phone: 724-887-3990 Email: [BeckyJuan4@zoominternet.net](mailto:BeckyJuan4@zoominternet.net)**