CCNS Summer Camp Agreement 2025

Child's Name _____ Date of Birth _____

Permission Agreement & Emergency Information

1. I understand and agree that **no refunds are given after April 1** unless we are able to fill the spot with someone on the waitlist. If a spot is available, we can move your child to another week of camp if it is done prior to camp starting in May and there is space available.

2. I/We grant permission for my child to use all of the play equipment, and participate in all the activities at camp, unless exceptions are noted below:

   _____

3. I/We grant permission for the staff to take whatever steps may be necessary to obtain emergency medical care, if warranted. These steps may include, but are not limited to the following:

   i. Administer first aid
   ii. Attempt to contact a parent or guardian
   iii. Attempt to contact the child's physician
   iv. Attempt to contact the parent through emergency contacts

   If we cannot contact the parent or physician, we will do any or all of the following:

   - Call another physician
   - Call an ambulance
   - Have child taken to the Emergency Room with a staff member

   Any expense incurred will be borne by the child's family.

4. CCNS will not be responsible for anything that may happen as a result of false information given at the time of enrollment.

5. I give permission for my child to be photographed for use on the CCNS Instagram account and Facebook Page. No names of children are ever used with the photos. Weekly Summer Camp social media posts are made throughout the summer.

Signed _____ Date _____
(Parent or Legal Guardian)

Emergency Contact Information

Child's Name _____

Mother's Name/Guardian's Name: _____

Cell Phone #: _____ Home #: _____

Email _____

Father's Name/Guardian's Name: _____

Cell Phone #: _____ Home#: _____

Email _____

The following person(s) may be contacted in an emergency, if we are unable to reach a parent/guardian:

Name: _____ Phone: _____

Address: _____ Relationship: _____

Name: _____ Phone: _____

Address: _____ Relationship: _____

Child's Physician: _____ Phone: _____

Physician's Address: _____

Child's Dentist: _____ Phone: _____

Dentist's Address: _____

Hospital Preference: _____

Parent's Health Insurance Company: _____

Health Insurance Policy Number: _____

Child's Allergies or Medical Restrictions (if none, write none) Please complete Medication Administration Forms if needed:

_____

Signed _____ Date _____
(Parent or Legal Guardian)