



Bryn Mawr Presbyterian Church Vacation Bible Camp
June 26 - 30, 2011



Information for Pre-Schoolers - Grade 5

Preschoolers must have been 3 by 9.1.2010

FIVE DAY CAMP SCHEDULE

Day 1: Sunday, 3-5 p.m., All Children & their Families
Days 2-5: Monday-Thursday from 9 a.m. - 12 noon, All Children

Camper Fees: \$85.00 per child (Non Refundable)
\$45.00 per child of Full Time (5 Days) Volunteers
Includes a CD for each family and a camp t-shirt for each child.
Scholarships available: Rev. Susan Rice, 610.520.8810

Easy Online
Registration
at www.bmpc.org

Registration Deadline
June 1, 2011

Make checks payable to:

BMPC VBC and
Mail to Jane Wilber
625 Montgomery Avenue
Bryn Mawr, PA 19010

For Office Use Only:

Check # _____
Amount \$ _____
Date Rec'd _____

Please Check Each Space! Online Registration: _____
Medical Form _____ Child Image/Name Release Form _____
T-Shirt Size _____ (Indicate size: Children's 2-4/6-8/10-12/14-16/18-20)
Camper Fee _____ (Checks payable to BMPC, indicate VBC in the memo line)

Questions? Contact Marcy DelOrefice, VBC Director marcydeloreface@aol.com

Mail Medical & Image/Name Release forms (required):
to Jane Wilber, BMPC, 625 Montgomery Ave., Bryn Mawr, PA 19010
We MUST have the medical, image/name release forms by June 1st.

CHILD IMAGE/NAME PERMISSION & RELEASE

Bryn Mawr Presbyterian Church staff members may wish to photograph, videotape, or otherwise record the activities of the Program participants for the purpose of promoting the Program. We may also publish your participant's name, grade, and image on Church related publications.

I give permission for my child in the Program to be videotaped, photographed, and/or recorded, in connection with the Program. I give permission for Bryn Mawr Presbyterian Church to use said videotaped, photographed, and/or recorded materials in BMPC publications, websites, CD's, DVD's or other media, for publicity purposes or in any other non-commercial manner that it chooses.

I hereby waive and release any rights that I may have to said videotaped, photographed, and/or recorded materials.

Child's Name (please print) _____

Parent/Guardian Name (please print) _____

Parent/Guardian Signature _____ Date _____

Forms are Available at www.bmpc.org



BRYN MAWR PRESBYTERIAN CHURCH

425 Montgomery Avenue | Bryn Mawr, Pennsylvania, 19001 | Tel: 610-526-4841 | Fax: 610-526-4275

MEDICAL FORM (page 1)

Complete this form and return it to the Church office. To ensure that your child receives proper medical care. Contact us immediately to update the form of any medical information changes or for specific events/trips.

Complete one form per registrant; please print clearly.

Participant's Last Name _____ Participant's First Name _____
 Participant's Date of Birth (MM/DD/YYYY) _____ Participant's Social Security # _____
 Parent(s)/Guardian _____
 Home Phone _____ Cell Phone _____ Work Phone _____ E-Mail _____
 Home Address _____ City _____ State _____ Zip _____

MEDICAL TREATMENT PERMISSION & RELEASE

I desire my child to participate in the Bryn Mawr Presbyterian activity described herein ("the Program"). I understand that there are hazards and risks, as well as benefits, associated with my child's participation in the Program. In consideration of the benefits of my child's participation in the Program, I, on behalf of myself, my child, my or their heirs, executors, administrators, agents, assigns, and other personal representatives, irrevocably and unconditionally remise, release, settle, compromise, and forever discharge any and all manner of suits, actions, causes of action, damages and claims, known and unknown, that I or my child, have or may have against Bryn Mawr Presbyterian Church and/or its trustees, officers, employees, agents assigns, contractors, or volunteers arising from or connected with my child's participation in the Program, including the securing of medical treatment for my child during my child's participation in the Program.

I give my permission to Bryn Mawr Presbyterian Church, its employees, agents, assigns, contractors, or volunteer supervisors to secure medical treatment for my child in the event that such treatment is needed during my child's participation in the Program or related activities. I agree to assume financial responsibility for the cost of such treatment.

The laws of the Commonwealth of Pennsylvania shall apply to this Medical Treatment Permission & Release. If any of the provisions, terms, clauses, or waivers or releases of claims or rights contained herein are declared illegal, unenforceable, or ineffective in a legal or other forum or proceeding, such provisions, terms, clauses or waivers and releases shall be deemed servable, and all other provisions, terms, clauses and waivers and releases of claims and rights contained herein shall remain valid and binding.

I sign this document with the intent to be legally bound by it. I am an adult, competent to sign this document. I am signing this document voluntarily. I have read it and I understand its contents.

Parent(s)/Guardian Name (*please print*) _____

Parent(s)/Guardian Name (*signature*) _____ Date _____

EMERGENCY CONTACT INFORMATION

Parent(s)/Guardian Name _____

Home Phone _____ Cell Phone _____ Work Phone _____ E-Mail _____

Contact Name _____ Relation _____

Home Phone _____ Cell Phone _____ Work Phone _____

Contact Name _____ Relation _____

Home Phone _____ Cell Phone _____ Work Phone _____

MEDICAL FORM (page 2)

INSURANCE INFORMATION

Participant's Last Name _____ Participant's First Name _____

Name of Insurance Policy Holder _____

Carrier _____ Policy # _____ Group # _____

PHYSICIAN INFORMATION

Physician's Name/Practice _____

Phone _____ FAX _____ E-Mail _____

Office Location _____ City _____ State _____ Zip _____

MEDICAL CONDITIONS

PLEASE CHECK ALL THAT APPLY

- | | | |
|--|---|--|
| <input type="checkbox"/> ADD | <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Mental Health Problems |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Motion Sickness |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dizziness/Fainting/Blackouts | <input type="checkbox"/> Orthopedic Problems |
| <input type="checkbox"/> Cardiac Problems | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Chronic Bed Wetting | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> (If applicable) Has your daughter had her first menstrual period? |

DATE of LAST TETANUS SHOT _____

ALLERGIES (Check)

- Aspirin
- Food Allergies
- Insect Stings
- Latex
- Other Medication
- Other Medication
- Penicillin
- Sulfa
- Tetracycline

REACTION (Describe)

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

TREATMENT (Medication/Dosage)

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

SPECIAL MEDICATION: *This information will be kept confidential. Please specify all medication(s) your child/student is currently taking, the dosage and how often it should be administered. Please note that we will not administer any medication during program hours unless we have written permission from you and your child/student's physician. Please be sure to supply any medication necessary for your child. All medications should be clearly labeled with name and instructions and placed in a sealed, clear plastic bag.* _____

ANY ACTIVITY RESTRICTIONS: _____

IMPORTANT: We are unable to dispense any medication without documentation from your child's doctor. This includes: aspirin, acetaminophen, ibuprofen, Benadryl, Epi-Pen.