

*Emergency Pick-up: _____ Relationship: _____

Phone/cell : (____) _____ (Photo Identification is Required each day)

Approved Pickup List: (Identification is Required before child is released)

Name: _____

Name: _____

FINANCES

The cost of the Summer Chess Camp is a total of \$450 per child for the entire one week camp – June 21-25, 2010. Installment payments can be arranged. The entire camp fee must be paid by May 31, 2010. A deposit must be submitted with application.

Make check/ money orders payable to: Huber Memorial Church, Att: Knights of Valor, 5701 York Road, Baltimore, MD 21212.

If you have any questions or concerns, please call Ken Tabron – (410) 433-8139 or Patrice Miles - (301) 821-6738.

PARENT/GUARDIAN CONSENT FORM

Student Name: _____

Parent/Guardian Name: _____

Daytime Telephone: _____ Cell Phone: _____

I, the parent or guardian of the above named child, hereby register him/her for participation in the Knights of Valor One Week Summer Chess Camp Program and fully agree to the rules and regulations. I do hereby release the Knights of Valor and its directors, representatives, employees, volunteers and Ashley Parr, LLC from any liability. I, the parent or guardian, release the Knights of Valor, Huber Memorial Church and Ashley Parr, LLC from all responsibilities from injuries of any nature incurred while participating in the Summer Chess Camp Program. I understand that my child will be supervised by a professional at all times, and that medical insurance is my responsibility.

EMERGENCY MEDICAL TREATMENT

In the event _____ (Camper's Name) becomes ill or sustains an injury while in the care of or under the supervision of the Summer Chess Camp Program coordinators, volunteers or other Knights of Valor representatives and Ashley Parr, LLC, they are given permission to administer first aid for his/her relief to the extent of rules of the State of Maryland. In case of an emergency, permission is given to take my child to the nearest appropriate emergency or clinic facility. A representative of the Knights of Valor or Ashley Parr, LLC will contact you or one of the persons on the emergency contacts immediately.

Family Doctor: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Allergies (if any): _____

Name(s) of any medications currently taken: 1. _____ 2. _____ 3. _____

Date of last Tetanus Shot _____

In case parent/guardian cannot be reached in an emergency, please contact: _____

Relationship: _____ Phone Number: _____

PLEASE NOTE: The Knights of Valor or Ashley Parr, LLC will not be allowed to administer any type of medication or allergy shots including the EpiPen.

