

**\$25 per class**  
when pre-registered

\$30 if less than  
7 days before class begins  
(if space available)

Date Registered\_\_\_\_\_

## The Fire Summer Art Camps Registration

Child's Name\_\_\_\_\_ Age\_\_\_\_\_

Address \_\_\_\_\_ City, Zip\_\_\_\_\_

Home Phone \_\_\_\_\_ Parent Cell Phone\_\_\_\_\_

Grade in Fall '09\_\_\_\_\_ Food Allergies?\_\_\_\_\_

Class # (s)\_\_\_\_\_,\_\_\_\_\_,\_\_\_\_\_,\_\_\_\_\_,\_\_\_\_\_,\_\_\_\_\_

Total Classes\_\_\_\_\_

X \$25\_\_\_\_\_

Total Due \_\_\_\_\_

**Discounts**  
**When you**  
**register for 4**  
**classes you**  
**get the 5<sup>th</sup>**  
**FREE!!**

Each Class includes: Snack, Quality Craft and Story/Lesson  
Limit 10 kids per class

## The Fire Summer Art Camps

### Wednesdays and Fridays

#### Please fill out the medical release form below:

Authorization to consent to treatment:

(I), (We), (parents), (guardian) of \_\_\_\_\_do hereby authorize The Fire, as agents for the undersigned to consent to any X-Ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care rendered but it is given to provide authority and power on the part of the aforesaid agents to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.

\_\_\_\_\_  
(Signature of Parent or Legal Guardian)  
Month/Day/Year

\_\_\_\_\_  
Please Print Name

**In case of emergency please leave a location and phone number where you can be reached:**

\_\_\_\_\_  
Phone\_\_\_\_\_