Red Skye Foundation Summer Riding Program Registration

Camper Name: _____ Age: _____

Parent/Guardian Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Doctor's Name: _____ Phone Number: _____

Doctor's Address: _____

Emergency Contact (available during the day):_____

Phone number: _____ Relationship: _____

Special Needs: _____

Allergies: _____

Please check all weeks that your child will be attending:

___ June 26- 29	___ July 17- 20	___ August 7- 10
No Program July 3- 6	___ July 24- 27	___ August 14- 17
___ July 10-13	___ July 31- August 3	___ August 21- 24

____I would like to drop my child off at 8AM

Emergency Medical Consent

In the event that I/we are unavailable for the purpose of providing parental consent, I/we hereby authorize a qualified emergency medical technician, physician, or hospital emergency room, as selected by the staff of Red Skye Foundation, to provide such hospital care including routine diagnostic procedures and medical treatment to my child. I understand that the consent and authorization herein granted does not include major surgical procedures.

_____ _____

Parent/Guardian Signature Date

Payment

Included with this form: Full Payment of: _____ Deposit of: _____

Please Circle One: CASH CHECK CREDIT/DEBIT

Card number: _____ Exp. Date: _____

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www.redskye.org