

2014 TARRYTOWN / SLEEPY HOLLOW SUMMER CAMP REGISTRATION FORM

(Please: One Child Registered Per Form)

PLEASE CHECK CAMP YOUR CHILD WILL BE ATTENDING: TOT CAMP: _____ DAY CAMP: _____

Name of Child: _____

Grade child will be ENTERING in September 2014 (if applicable): _____

Child's Birth Date: _____ Age: _____ Circle One: Male Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Work #: _____ Cell #: _____

Parent / Guardian Name: _____

Name of Emergency Contact: _____

Emergency Contact Phone #: _____

Please Note any Medical Information: _____

***** NO REGISTRATION WILL BE ACCEPTED WITHOUT IMMUNIZATION RECORD*****

Check week(s) child will be attending:

PLEASE NOTE: For Tot and Day Camp, you must register for a **minimum** of two (2) consecutive weeks.

WEEK # 1 June 30 to July 3*	_____	Early Arrival: _____	Extended Day: _____
WEEK # 2 July 7 to July 11:	_____	Early Arrival: _____	Extended Day: _____
WEEK # 3 July 14 to July 18:	_____	Early Arrival: _____	Extended Day: _____
WEEK # 4 July 21 to July 25:	_____	Early Arrival: _____	Extended Day: _____
WEEK # 5 July 28 to August 1:	_____	Early Arrival: _____	Extended Day: _____
WEEK # 6 August 4 to August 8:	_____	Early Arrival: _____	Extended Day: _____

*PLEASE NOTE: There is **NO** camp on Friday, July 4th.

Mail completed registration form to:

Tarrytown Recreation Department
PO Box 292
Tarrytown, New York 10591

WAIVER OF LIABILITY:

I hereby agree to hold harmless the Villages of Tarrytown & Sleepy Hollow, the respective Board of Trustees thereof, the agents, employees and volunteers from any claim whatsoever, for property damage or personal that I / my child may sustain as a result of his/her participation in the activities of the Tarrytown / Sleepy Hollow Day Camps, including swimming, field trips and/or other events sponsored in conjunction with the Tarrytown Recreation Department and the Sleepy Hollow Recreation Department.

SIGNATURE OF PARENT/GUARDIAN: _____ Date: _____

PLEASE NOTE: There are **NO** refunds except for illness. The refund request must be in writing and must be accompanied by a doctor's note. Any refund will be prorated based on the date received, with a \$10.00 processing fee attached.

REGISTRATION INFORMATION: (for office use only)

Immunization Record Received: _____ Date: _____ Level: _____

WEEK # 1 Paid: _____ Check #: _____ Date: _____ WEEK # 4 Paid: _____ Check #: _____ Date: _____

WEEK # 2 Paid: _____ Check #: _____ Date: _____ WEEK # 5 Paid: _____ Check #: _____ Date: _____

WEEK # 3 Paid: _____ Check #: _____ Date: _____ WEEK # 6 Paid: _____ Check #: _____ Date: _____