

TARRYTOWN / SLEEPY HOLLOW DAY CAMPS 2009 REGISTRATION FORM

(Please: One Child Registered Per Form)

PLEASE CHECK CAMP YOUR CHILD WILL BE ATTENDING:

TOT CAMP: _____ DAY CAMP: _____ SPORTS CLINIC: _____

NAME OF CHILD: _____

GRADE CHILD WILL BE ENTERING IN SEPTEMBER 2009 (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 THE WEEK(S) YOUR CHILD WILL ATTEND:

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

WEEK # 1 July 6 to July 10: _____ Early Arrival: _____ Extended Day: _____

WEEK # 2 July 13 to July 17: _____ Early Arrival: _____ Extended Day: _____

WEEK # 3 July 20 to July 24: _____ Early Arrival: _____ Extended Day: _____

WEEK # 4 July 27 to July 31: _____ Early Arrival: _____ Extended Day: _____

WEEK # 5 August 3 to August 7: _____ Early Arrival: _____ Extended Day: _____

WEEK # 6 August 10 to August 14: _____ Early Arrival: _____ Extended Day: _____

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: _____

WEEK #1 Paid: _____ Check #: _____ WEEK #2 Paid: _____ Check #: _____

WEEK #3 Paid: _____ Check #: _____ WEEK #4 Paid: _____ Check #: _____

WEEK #5 Paid: _____ Check #: _____ WEEK #6 Paid: _____ Check #: _____