

Trinity School  
Summer Camp 2024

Thank you for your interest in our Summer Camps. We are look forward to providing your child with a fabulous camp experience! Please complete this form and return it with your full payment.

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Additional Contact Numbers: \_\_\_\_\_

**Please list all allergies (describe severity and treatment), medications, and any and all medical conditions that we should be aware of:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

The following people are allowed to pick up my child: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please circle each day you are registering for.

Camp Dates	Title	Price
June 10-13	Garden Time	\$325
June 17-20	Whittling Away the Summer	\$325
June 24-27	Kites and Kestrels	\$325
July 1-4	Fireworks	\$325
July 8-9	Wild Shelters	\$325
July 22-25	Blossoms and Boats	\$325
July 29-Aug 1	Builders Week	\$325
August 5-8	Whittling Away the Summer	\$325
August 12-15	Wildcrafting	\$325

Total payment enclosed: \_\_\_\_\_

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**Please have both parents or guardians sign the following:**

**Waiver/Release/Assumption of Risk**

I/  
We \_\_\_\_\_  
\_\_\_\_\_, in consideration of the educational programs to be provided to my  
child, \_\_\_\_\_, on  
behalf of myself/ourselves and my/our child, release, waive, hold harmless and  
forever discharge

Trinity School Idaho, its officers, directors, employees, volunteers, independent  
contractors, agents and/or representatives of any kind, as well as the owner of  
any property leased or used by Trinity School, from any and all liability for all  
actions, all bodily injury and property damage claims, demands, or damages  
accruing to me/us resulting from any known or unknown injury, loss, or damage  
to person or property, or death, together with any attorney's fees and costs of  
litigation including, but not limited to those on appeal or in bankruptcy court,  
sustained or incurred by me/us, my/our child or any third party in or about the  
premises at 31 Lower Broadford Road, Bellevue, Idaho, while my child is  
participating in any of the programs offered by Trinity School. I/we agree to  
assume all risks of activities during the programs and acknowledge that I/we are  
aware of the risks inherent in allowing my child/children to visit the site and farm  
and participate in programs. I/we acknowledge that this pertains to any risk or  
damage resulting from Covid 19 related effects. I/we agree this waiver and  
release shall legally bind me/us and my/our child, and my/our heirs, trustees,  
personal representatives and assigns. I/we also grant Trinity School permission  
to use, without compensation, photographs of my/our child/children in  
publications and other promotional materials. I/we are aware that we are  
releasing certain legal rights by this Contract that we otherwise might have.

Parent  
Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent  
Signature \_\_\_\_\_ Date \_\_\_\_\_

**Emergency Information**

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Child's Name: \_\_\_\_\_

Parent/Guardian to contact in case of emergency \_\_\_\_\_

Primary phone \_\_\_\_\_ Secondary phone \_\_\_\_\_

Second Parent/Guardian or emergency  
contact \_\_\_\_\_

Primary phone \_\_\_\_\_ Secondary  
phone \_\_\_\_\_

Preferred local physician: \_\_\_\_\_

Physicians  
phone: \_\_\_\_\_

In case of emergency and the parents/guardians cannot be reached, please  
notify:

Name and phone numbers: \_\_\_\_\_

Name and phone numbers: \_\_\_\_\_

### Emergency Medical Treatment Procedure and Consent for Treatment

It is the general policy of Trinity School to have transported to the local emergency room any child who is injured while in our care and requires emergency treatment. We will follow this general policy if the person in charge judges that a delay in securing treatment would not be in the best interest of the child. Whenever possible, parents will be notified and asked to take their child to their family physician for medical treatment.

Yes, I would like the above procedure followed for  
\_\_\_\_\_

In the event I cannot be reached, I hereby authorize the calling of a licensed physician at my expense to provide whatever emergency medical or surgical treatment is necessary.

Parents Signature \_\_\_\_\_

No, I do not want the above policy followed for  
\_\_\_\_\_

I prefer the following procedure:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_