

# FIRSTLIGHT ARTS ACADEMY 2010 Camp REGISTRATION FORM

Please Print this form, and mail with a check (payable to Firstlight) to our office at: **109 Chapelwood Lane, Franklin, TN 37069**  
 To ensure a reservation for each camp, we require the full camp fee of **\$135** for ART BUGS and/or **\$150** for COLOR CAMP.  
 Each class meets from 9:30 to noon for one week, Mon through Fri. See our policies for more information.  
 One form per student. *Please write Clearly - Especially numbers - Thanks!*

<b>Circle camp and write dates:</b>			<b>Mother/Guardian</b>		
Art Bugs Camp	Dates:		Full Name		
Color Camp	Dates:		Mailing Address (if different)		
Student Name:	Prefer to be called:		Place of Employment		
Address			Home Phone (    )		
City	State	Zip	Work Phone (    )		
Date of Birth:	Male <input type="checkbox"/> Female <input type="checkbox"/>		Cell Phone/Pager (    )		
Age June 1, 2010	Grade 09/10:		Cell Phone/Pager (    )		
Academic School:	Grade 09/10:		E-mail (Required):		
Church:	Affiliation:		<b>Father/Guardian</b>		
Siblings (and their ages):			Full Name		
Person Responsible for Payments (if other than parent):			Mailing Address (if different)		
Relationship to student:			Place of Employment		
Complete Mailing Address:			Home Phone (    )		
Day Phone: (    )			Work Phone (    )		
Evening Phone: (    )			Cell Phone/Pager (    )		
I understand that space is limited and that my signature below is a full commitment to camp*			Cell Phone/Pager (    )		
Signed: _____			E-mail		
Date: _____			<b>Emergency Contacts</b>		
*Cancellation requires a 30-day written notice. \$25 non-refundable cancellation fee taken from refund of camp fee.			<b>OTHER THAN PARENTS:</b>		
<i>Please tell us how you heard about Firstlight art classes?</i>			(We will always attempt to contact parents first.)		
_____			We suggest someone who is available during the student's class time		
_____			_____		
<b>Student Medical Release (Please Print)</b>			<b>CONTACT 1</b>		
Doctor's Name:	Dr.'s Phone#: (    )		Full Name		
Medical Insurance Carrier:	Insurance Phone #:		relationship to Student		
Policyholder's Name:	Policy #:		Day Phone (    )		
Medical Facility Request:	_____		Cell Phone/Pager (    )		
Any emotional or behavioral conditions?			Evening Phone (    )		
_____			_____		
Any presently existing or persistent condition/infection? (i.e., asthma, bursitis, etc.)			<b>CONTACT 2</b>		
_____			Full Name		
Please list any medications student is currently taking			relationship to Student		
_____			Day Phone (    )		
If student is diabetic or hypoglycemic, please indicate the recommended food/drink in case of emergency:			Cell Phone/Pager (    )		
_____			Evening Phone (    )		
Does student wear: Eyeglasses      Contacts      Hearing Aids			_____		
Any other information we should be aware of?			_____		
_____			_____		
Liability Release			_____		
I/We hereby release Dennas Davis, Firstlight Arts Academy, its agents, employees, and volunteer assistants from any liability whatsoever arising out of any injury, damage, or loss which may be sustained by the above-named student while participating in classes and activities offered by Firstlight.					
In case of emergency, I/we grant any staff or faculty member of Firstlight Arts Academy permission to seek medical care for the above-named student.					
Signature of Parent			Date		
_____			_____		