

Camp on the Hill 2010 Swim School Application

- Eight lessons per two-week session
Mon., Tues., Thurs., Fri. (no lessons on Wednesdays)
- Cost: \$85.00 per session

OFFICE USE ONLY

All fees are due with registration application.

STEP 1: Student Information

Last Name _____ First Name _____

Age ____ Gender ____ Date of Birth ____/____/____

Street Address _____

City _____ State _____ Zip _____ - _____

Parent's/Guardian/s Name(s) _____

Home Phone (____) _____ - _____

Father's Work/Cell (____) _____ - _____ Mother's Work/Cell(____) _____ - _____

STEP 2: Sessions

Please check the session(s) and time preference you would like your child to attend. **Indicate first choice ("1") and second choice ("2") for each session. Sessions subject to availability and enrollment trends, not necessarily by date enrolled.**

Session 1	Session 2	Session 3	Session 4
6/14 – 6/25	6/28 – 7/9	7/12 – 7/23	7/26 – 8/6
__4:00-4:30 pm	__4:00-4:30 pm	__4:00-4:30 pm	__4:00-4:30 pm
__4:30-5:00 pm	__4:30-5:00 pm	__4:30-5:00 pm	__4:30-5:00 pm
__5:00-5:30 pm	__5:00-5:30 pm	__5:00-5:30 pm	__5:00-5:30 pm

STEP 3

Is your child registered for Camp on the Hill? __Yes __No

SWIM LEVEL (check one)

____ **Beginner** - cannot swim in the 5-foot-deep pool or in the 10-foot-deep pool by themselves

____ **Intermediate** - can swim in both the 5-foot-deep pool and the 10-foot-deep pool by themselves

____ **Advanced** - can swim in both the 5-foot-deep pool and the 10-foot-deep pool by themselves, plus can swim most of the strokes

STEP 4: Payment

- Payment in full is due at time of registration.
- Make check payable to **Camp on the Hill Swim School**.
- The Emergency Form MUST be completed and included with your Swim School Application or your application will not be processed.
- Applications and payments MUST be mailed in.
- Mail application and payment to:
Camp on the Hill Swim School
500 Sands Drive
San Jose CA 95125

Amount Due

# of sessions	
cost per session	\$85.00
TOTAL	
Method of Payment check # _____	

Camp on the Hill 2010 Emergency Form

PLEASE PRINT ALL INFORMATION CLEARLY

Camper's Last Name _____ First Name _____

Date of Birth ___ / ___ / ___ Home Phone () _____ - _____ Today's Date ___ / ___ / ___

Mom's/Guardians Work Phone () _____ - _____ Mom's/Guardians Cell Phone () _____ - _____

Dad's/Guardians Work Phone () _____ - _____ Dad's/Guardians Cell Phone () _____ - _____

(I/We), (Parents, Guardians) of _____ do hereby authorize the sponsor representing the First Baptist Church of San Jose (aka Church on the Hill) as agent for the undersigned to consent to any medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under general or special supervision of, any physician and/or surgeon licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at office or said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care required and is given to provide authority on the part of aforesaid agent to give special consent to any type of the services listed above, but not limited to.

This authorization is given pursuant to the provision of Section 25.8 of the Civil Code of California. This authorization is to be effective until it is revoked in writing to said agent.

As parents, we understand that we are responsible for all medical cost and that church insurance will be in excess to our family's own insurance. In addition, it is our responsibility to inform the aforesaid agent of any significant changes in our child's health that occur after the signing of this document.

Printed Name of Father, Mother, or Legal Guardian

Signature of Father, Mother, or Guardian

Emergency Contact (other than Parent or guardian)

Relationship of Emergency Contact to Child

Emergency Contact's Phone Number

Family Physician

Physician's Address

Physician's Phone Number

Insurance Company

Policy or Group Number

Please check all that apply to the above named child

- Rheumatic Fever Asthma Upset Stomach
 Frequent Colds Eye, Ear, nose, throat difficulties
 Diabetes Heart Conditions
 Epilepsy or other Nervous System Disorders

Explain: _____

Please list any known allergies to food and/or medicine:

- Physically challenged Learning Disabilities

Explain: _____

Date of last tetanus shot ___ / ___ / ___

Check one if applicable: Is your child a:

- Non-swimmer Weak Swimmer

Additional
Comments _____

