



Name: _____ Nickname: _____

Age: _____ Birthday: _____

Mom's Name: _____ Work # _____ Cell # _____

Dad's Name: _____ Work # _____ Cell # _____

Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

E-mail: _____

Emergency Contact Information

1) Name _____

Relation to Child _____ Phone # _____

2) Name _____

Relation to Child _____ Phone # _____

Physician's Name _____ Phone # _____

Medications currently being taken: _____

Allergy/Diet restrictions: _____

Date(s) attending Cooking Camp: _____ AM or PM Session _____

Is child enrolled in Camp 119 also? _____

To the best of my knowledge, the information in this health form is correct. My child has permission to participate in all Cooking Camp activities except those noted above.

In the event of an emergency in which I or the emergency contact person cannot be reached, I _____

hereby grant permission to One Nineteen Health and Wellness to give Emergency Medical Services to _____

(child's name) by the physician at _____ Hospital/Medical Center to secure proper treatment for, and including, but not limited to, injections, anesthesia, or surgery for my child as named herein.

Participation Waiver

I hereby, for myself and administrators, wave and release any and all rights and claims I may have against One Nineteen Health and Wellness and their employees, agents, successors, and representatives for any and all injuries which may be suffered by my child while participating in this program.

On this day _____ of _____ 20_____

parent/guardian signature / _____ date

Print Name _____

Authorized Pick-up List (if Camp 119 participant, not necessary to repeat information)

Please list below the names of the individuals who are authorized to pick up your child from Kid's Cooking Camp.

Name _____

Relation to Child _____

Name _____

Relation to Child _____

Name _____

Relation to Child _____

Signed _____ Date _____

For Office Use Only:

Fees

\$175 each Camp Session (AM or PM) Amount paid: \$ _____ Date: _____

\$157.50 each Camp Session (AM or PM) Amount paid: \$ _____ Date: _____
(Discounted for each additional sibling or week)



One Nineteen

Care you can believe in