VISIONSUSA

DAY CAMP ENROLLMENT FORM
Day Camp Times and Options

Visions USA, LLC
32 Pheasant Drive, Asheville, NC 28803
Phone: (828) 333-3905 • Mail: info@visionsusa.org

Family Name

First Name Middle Name

Gender Male Female Date of Birth Month Day Year

Week	Dates	Excursion*	Price*
Week 1	7/3 to 7/7 — no day camp on 4th	*Dollywood*	$130
Week 2	7/9 to 7/13	*White Water Rafting*	$125
Week 3	7/16 to 7/20	***Green River Tubing***	$125
Week 4	7/23 to 7/27 — no day camp on 27th	*Carowinds*	$125
Week 5	7/30 to 8/3	*White Water Rafting*	$125
Week 6	8/6 to 8/10	***Green River Tubing***	$125
Week 7	8/13 to 8/17 — no day camp on 17th	*Carowinds*	$125

Yes, please plan my child in for the following excursion(s)

Are you hosting, and if so, are you planning on taking advantage of our one week free tuition for your own child? Yes No

If so, please indicate which week. #

Parents' Participation

Parents, we invite you to join in for any of the excursions we offer this summer. It is your choice. The following rates include the activity (Atlanta: incl. Braves ticket and hotel), meals, and transportation with the group.

Excursion/Date: *Week 1:* Dollywood - July 5th ($75); *Week 2:* Rafting - July 13th ($45); *Week 3:* Atlanta w/Braves Game & Hotel overnight; July to 17th/18th ($200); *Week 4:* Carowinds - July 27th ($60); *Week 5:* Rafting - August 3rd ($45); *Week 6:* Atlanta with Braves Game & Hotel overnight - August 8th/9th ($150); *Week 7:* Carowinds - August 17th ($60)

If you are enrolling your child in our 6-day trip to Orlando, please select your trip:

Orlando, Trip 1 (July 28 to August 3) Orlando, Trip 2 (August 18 to August 24)

Cost per trip: $1,500*

* All-inclusive (ex. transportation from/to Asheville, room and board, admissions theme parks, Cocoa Beach excursion)

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Student Information

Home Address

Parent Name

Best Contact Email Best Parent Phone #

Emergency Contact Persons' Information

Name 1 Phone

Name 2 Phone

Health Information Student

Does your child suffer from any allergies? Yes No
If yes, please specify and describe the severity and treatments.

Does your child follow a special diet? *If so, please explain.* Yes No

Has your child ever been hospitalized? *If yes, please explain.* Yes No

Please indicate any other pertiinent medical information and/or conditions; ex. ADHD, anxieties, seizures.

Please indicate any medications your child is taking currently and their purpose.

Does your child administer their own medication? Yes No

Please name any prescriptive/nonprescriptive drug(s) that should not be administered by your child.

Date of last Tetanus injection/booster:

Is your child a proficient swimmer? *If no, please elaborate.* Yes No

Are their any activities your child should not participate in for medical or general health reasons?

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Miscellaneous Information

Name of Health Insurance Company

Insurance Card #

Diet

Does your child follow a special diet? Yes No If yes, please explain.

Does your child suffer from any food-related allergies? Yes No If yes, please elaborate.

Medical Treatment Authorization and Consent

In case of any emergency related to your child, we will notify you immediately. A qualified staff member will administer first aid treatment. We ask you to read and sign the following.

I, , the parent/guardian of hereby authorize, seek and consent to medical treatment as deemed necessary by a qualified licensed First Aid representative of Visions USA, LLC or medical and healthcare professional. This authorization is for the time period when my child is in the care of Visions USA, LLC and while his/her participation in the organization's programming.

In the event that my child should require medical care or treatment, I agree to be financially responsible for any costs incurred as a result for such treatment. I am aware and understand that I should carry my own health insurance for my child.

Signature of Parent/Guardian Date Month Day Year

Accident Waiver and Liability Release

As parent/guardian, I hereby assume all the risk of a participation in the Visions USA, LLC program for myself and my child/ren. I will not hold Visions USA, LLC liable for any bodily injury or loss of personal valuables, unless damage occurs as a result of a Visions USA, LLC representative's willful actions, neglect or recklessness.

Signature of Parent/Guardian Date Month Day Year

Do you grant Visions USA permission to take and publish photos of your child for marketing purposes? Yes No

Upon completion, please send this application via scanned email attachment to *info@visionsusa.org* or mail it to the Visions USA office. We will send you a confirmation and invoice upon receipt.

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