

Wizards of the Mind

2009 Summer Camp Registration Form

Student Name _____ Age _____ Grade Next Fall _____ DOB _____

USCF Rating if any _____ Tennis Experience (please circle one) Beginner Intermediate Advanced

Home address _____ City _____ State _____ ZIP _____

Home phone _____ Parent's e-mail _____ Alternative e-mail _____

Mother's/guardian's name _____ Daytime phone _____ Mobil phone _____

Father's/guardian's name _____ Daytime phone _____ Mobil phone _____

Emergency Contact name _____ Daytime phone _____ Mobil phone _____

# of Weeks	FULL DAY RATE		HALF DAY RATE		Extended Day Rate (6-6:30pm)
	Weekly Rate based on multiple weeks	Total Full Day	Weekly Rate based on multiple weeks	Total Half Day Rate	
Six Weeks	\$325	\$1,950	\$195	\$1,170	\$180
Five Weeks	\$350	\$1,750	\$210	\$1,050	\$150
Four Weeks	\$360	\$1,440	\$216	\$865	\$120
Three Weeks	\$380	\$1,140	\$228	\$685	\$90
Two Weeks	\$400	\$800	\$240	\$480	\$60
One Week	\$410	\$410	\$250	\$250	\$30

Week #	Dates	Check Weeks Selected	Full or Half day option (F/H)	Extended Day
1	June 29-July 3			
2	July 6-July 10			
3	July 13 - July 17			
4	July 20 - July 24			
5	July 27 - July 31			
6	August 3 - August 7			

Discounts: 10% discount for additional camper from the same family.

Total Camp Fee: \$ _____.

Deposit of 50% of total camp fee is due at registration.

MEDICAL INFORMATION

Please list any allergies, fears, disability, medical conditions or other special needs camp's staff should be aware of: _____

Name of family physician: _____ Phone _____ Insurance Company _____ HMO or PPO _____

Insurance company address _____ City _____ State _____ ZIP _____

Policy subscriber's name _____ Policy #: _____ Group #: _____

MEDICAL TREATMENT AUTHORIZATION: I hereby authorize the Wizards of the Mind to arrange for transportation in case of accident or acute illness of my child. In the event it is impossible to receive instructions from me for my child's care, consent is given to any licensed physician and/or surgeon called or to whom my child is taken, for treatment by him/her to provide care that includes routine diagnostic procedures (i.e., x-rays, blood and urine tests) and medical treatment as necessary to my minor son/daughter and administration of drugs and medication and to perform such surgical treatment as he/she shall think the existing emergency requires for pain relief or preservation of my child's life, and/or health and well-being. I/We agree to the release of any records necessary for treatment, referral, billing, or insurance purposes to the appropriate medical care provider.

RELEASE: I/We, the undersigned, individually and as parent(s) and/or guardian(s) of _____, a minor, ask that he/she be admitted to participate in Wizards camp sponsored by Wizards of the Mind, Inc. In consideration of such admission, I/we do hereby agree to release, discharge, and hold harmless the Wizards of the Mind, its officers, agents, and employees of and from all causes, liabilities, damages, claims, or demands whatsoever on account of any injury or accident involving the said minor arising out of the minor's attendance at the summer camp or in the course of activities held in connection with the camp. We have read, understand and fully accept the policies of the Wizards of the Mind Camp.

Check for \$ _____ is enclosed (please circle: deposit, balance, full payment).

Parent/Guardian Signature: _____ Date _____

Please mail registration, policy form and payment to Wizards of the Mind, 15 Center Street, Springfield, NJ 07081

Office Use Only:	<input type="checkbox"/> Reg form	<input type="checkbox"/> Policy Form
<input type="checkbox"/> Allergies	<input type="checkbox"/> Deposit payment	<input type="checkbox"/> Balance Pmt