

Exploring Music for Kids!!



REGISTRATION FORM

Please complete both sides

Date: Saturday, June 25
Time: 9AM to 3PM (snack and light lunch included)
Fee: \$10 (*limited scholarship assistance available*)
Location: Grace Episcopal Church, 300 Westminster St, Providence RI

*Exploring Music for Kids is for young people **entering Grades 1–6** in the Fall of 2016*

Name: _____

Birth Date: _____ Grade (Fall 2016): _____

Address: _____

City/ST: _____ ZIP: _____

Name Parent/Guardian: _____

Home Phone: (____) _____

Cell Phone: (____) _____

Work Phone: (____) _____

E-Mail Address: _____

Emergency Contact:

Name: _____

Phone: (____) _____

Relationship to Child: _____

Please enclose a check, money order or cash for \$10

Payable to: Grace Church in Providence

Scholarships are available.

Registration Deadline: June 23, 2016

For further information please contact:

Vince Edwards, Director of Music at Grace Church

401-331-3225, x4 or

vedwards@gracepvd.org

**EXPLORING MUSIC and THE ARTS WEEK
PERMISSION and MEDICAL FORM**

_____ has my permission to attend Grace Church's EXPLORING MUSIC FOR KIDS, Saturday, June 25, 2016, from 9 AM to 3 PM, held at Grace Church in Providence, 300 Westminster St, Providence, RI.

I understand that:

- The on-site camp will be under the supervision and direction of adult leaders. I waive any claim against Grace Episcopal Church and their approved leaders. In case of medical emergency, I understand every reasonable effort will be made to contact me. If I cannot be reached, I/we, the parent(s) or legal guardian(s) of _____, a minor, hereby authorize and consent to the physician selected by the approved leader, sponsor or chaperone to hospitalize and select proper treatment including but not limited to injection, anesthesia or surgery for my child.
- I give permission for photos taken by the Grace Church photographers to be used on the Grace Church website. No names of campers will be posted with photographs.

Signature: _____ Relationship: _____

_____ Date: _____

Family Physician: _____

Phone: (____) _____

Family Dentist: _____

Phone: (____) _____

Insurance Company: _____

Phone: (____) _____

Name of Policy holder: _____

Policy No.: _____

Please attach a copy of participant's medical insurance card

Any drug or food allergies: _____

Special Needs (including dietary): _____

If I cannot be reached, please contact: _____

Phone: (____) _____ Relationship: _____