



Essex River Basin Adventures

SUMMER SEA KAYAK ADVENTURE PROGRAM

Registration Application

| | | | |
|---|-----------------|---------------|--------------|
| First Name | Last Name | Date of Birth | Sex |
| Street Address | City | State | Zip |
| Parents/Guardian | Phone-Day | | |
| Phone-evening | Cell Phone | | |
| Email | | | |
| <i>Please select week you would like to enroll:</i> | | | |
| Week 2 | July 2, 3, 5, 6 | half day | _____ \$225. |
| Week 3 | July 9 - 13 | half day | _____ \$275. |
| Week 4 | July 16 - 20 | half day | _____ \$275. |
| Week 5 | July 23 - 27 | full day | _____ \$325. |
| Week 6 | July 30 - Aug 3 | full day | _____ \$325. |
| I fully understand the potential risks involved in sea kayaking and hereby release the ERBA staff from liability should as accident, illness, or injury occur, provided adequate safety precautions have been taken. In case of emergency, I understand that every effort will be made to secure proper treatment and I give my permission for such treatment. I also understand that my child's health/accident insurance will provide coverage for any accident, injury or illness. | | | |
| Parent/guardian Signature_____ | | | |
| Date_____ | | | |
| *Registration will be accepted on a first come first serve basis. Please return this application with a \$100.00 non-refundable deposit, release form, emergency form, and Physicians health form to: ERBA * PO BOX 270 * ESSEX, MA * 01929 | | | |
| <u>BALANCE is due by June 1, 2012</u> Any questions please call 978-768-3722 | | | |

EMERGENCY INFORMATION FORM

CAMPERS NAME _____

ADDRESS _____

TELEPHONE _____

DATE OF BIRTH _____

FATHERS NAME _____ MOTHERS NAME _____

ADDRESS _____ ADDRESS _____

TELEPHONE _____ TELEPHONE _____

PLEASE LIST THE NAMES OF TWO PEOPLE TO NOTIFY IN CASE OF EMERGENCY

NAME _____ NAME _____

ADDRESS _____ ADDRESS _____

TELEPHONE _____ TELEPHONE _____

MEDICAL INFORMATION

PEDIATRICIAN/DR. _____ INSURANCE

CARRIER _____

ADDRESS _____ SUBSCRIBER _____

TELEPHONE _____ POLICY NO. _____

DENTIST NAME _____ TELEPHONE _____

MEDICAL TREATMENT CONSENT

The undersigned guardian of _____ consents to ERBA taking such child to a hospital, doctor or dentist when, in the opinion of ERBA personnel, treatment appears necessary and to the treatment of such child by such hospital doctor or dentist when, in the opinion of the care provider, such treatment appears reasonably necessary in circumstances where the parent or guardian cannot be reached in a timely manner to give consent. This consent will remain in effect as long as the child participates in an ERBA program.

DATE _____

PARENT/GUARDIAN SIGNATURE _____