Srodowisko Week 2017 Application

_____July 16 – 22 (boys 14-18 by Dec. 31, 2017)
_____July 30 – Aug. 5 (girls 14-18 by Dec. 31, 2017)

Name:_____ Home Phone:_____ Cell Phone:_____
Address: _____
Date of Birth:____/_____/_____ Your Email:_____
Parent's Name:_____ Cell:_____e-mail_____
Parent's Name:_____ Cell:_____e-mail_____

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For Youth applying ages 14 -18: *(limit 20 for each session)*
Cost: $250 ($50 deposit due with this form, balance due June 15, 2017)

(circle one) check cash credit card charge: _____ _____ _____ _____ exp: ___/_____

(Payable to Quiet Waters, Inc.) (circle one): **MC Visa Discover**

Please mail application and releases to**: Quiet Waters**; 11045 Ketchum Road, North Collins, NY 14111

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I, _____ (parent's name printed), give permission to the above named participant to attend the Quiet Waters Srodowisko week.

If needed for health reasons, I give permission for my child to receive standard medical care by appropriate Health care personnel. I give permission to Quiet Waters and its agents to share and disclose medical information to those who are responsible for the treatment and care of my child. I release Quiet Waters and its agents of all responsibility and consequences that may arise as a result of any injury suffered and resulting treatment. Further, I agree to accept any and all financial responsibility as a result of scheduling medical treatment.

My child agrees to abide by all rules and regulations stated by Quiet Waters Srodowisko Staff. I understand Quiet Waters will not be liable if my child fails to cooperate with regulations and that any infraction of the rules may result in immediate dismissal from the Srodowisko at my expense.

I authorize Quiet Waters, Inc. to tastefully use photographs, video, and audio media produced during the Srodowisko week of my child and by my child for promotion, contests and in an effort to spread the Gospel. This may include printed and/or digital material posted on the internet, radio, or sold.

X _____ _____
Signature of Parent/Guardian Date

Medical Information

Family Physician: _____Phone: _____
Practice Name/ Address: _____
Allergies: _____
Current Medications: _____
Medical History: _____
Insurance Carrier:_____ Policy #_____
Emergency contact: Name(s): _____ Home: (___)_____
Address: _____ Cell: (___) _____