

WACO SUMMER CAMP REGISTRATION & RELEASE FORM**Name of Camp:** _____ **Dates of Camp:** _____**To be completed by parent or guardian. Please print.**Pay directly on our website at www.wacoairmuseum.org and email this form to campdir@wacoairmuseum.org or return to the WACO Air Museum, 1865 S. Co Rd 25A, Troy, OH 45373.

Last Name:			First Name:			Shirt Size (Aviation Academy Only)	
Sex: M or F	Age:	Birthdate:	Grade entering:	School:			
Street/City/State/Zip							
<input type="checkbox"/> Food Allergies – List:							
<input type="checkbox"/> Medication Allergies – List:							
<input type="checkbox"/> Severe allergic reactions to insect bites – List:							
<input type="checkbox"/> Any medical conditions such as diabetes, asthma, seizures, heart/blood condition, physical handicap, or other? List:							
<input type="checkbox"/> Any handicap condition, either developmental, behavioral, mental or physical? List:							
(Please recognize that we are not equipped to handle all conditions and may have to deny participation in some cases.)							
<input type="checkbox"/> Any over-the-counter medications you DO NOT want to be dispensed to your child? List:							
EMERGENCY CONTACT INFO							
Mother's Name:		(H) Phone:		(C) Phone:		Legal Custodian: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Address (if different than above)				Email:			
Place of Employment:		Work Address:			Work Phone:		
Father's Name:		(H) Phone:		(C) Phone:		Legal Custodian: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Address (if different than above)				E mail:			
Place of Employment:		Work Address:			Work Phone:		
Who is the Emergency Contact(s) during the week of camp if other than mother/father:							
Name:		Relationship:			Home/Cell Phone:		
Name:		Relationship:			Home/Cell Phone:		

Consent to Grant Medical Treatment: This will authorize the provision of emergency treatment of students who become ill or injured while under WACO Learning Center authority when parents or guardians cannot be reached. I hereby give consent for the following medical care providers and local hospital to be called.	
Physician	Phone
Dentist	Phone
Medical Specialist	Phone
Preferred Hospital	Phone
Parent/Guardian Signature:	Date:

Activity Release I (undersigned) give my permission for my child (named on p. 1 of document) to attend the events, activities, and field trips associated with the WACO Aviation Summer Camp. I further give my permission for my child to be transported to and from any scheduled field trips by hired and/or volunteer drivers authorized by WACO Historical Society.	
Acknowledgement of Liability Limitations and Assumption of Risk I (undersigned) acknowledge that I will not hold WACO Historical Society, its employees and/or its volunteers liable for property damage, personal injury or accidental death, during the activities of WACO Aviation Summer Camp. Accordingly, parents assume risks any time students are permitted to travel and/or participate in summer camp-related events.	
Parent/Guardian Signature:	Date:

Picture Release I (undersigned) give permission to WACO Historical Society and their agents to use my picture, voice, and/or comments in promotion of education and this organization. I understand and agree that these images/recordings are the property of WACO Historical Society and may be released to the media and/or published in print documents, broadcast media, or via internet outlets without compensation.	
Student Signature:	Date:
Please Print:	
Parent/Guardian Signature:	

Behavior Agreement: I am aware that I am under the jurisdiction and supervision of the WACO Historical Society, its employees and volunteers. I acknowledge that I will be on my best behavior and must conform to any reasonable instructions from the volunteers/chaperones. I understand I will be subject to appropriate disciplinary action for violations of this agreement, which could involve my parent coming to pick me up from the activities of the day, my parent accompanying me for the remainder of the activities, or my removal from the activity or group.	
Student Signature:	Date:
Printed Name:	
I have read the Child's Behavior Agreement and will support it by becoming involved if called upon to do so.	
Parent/Guardian Signature:	Date:
Printed Name:	

FOR OFFICE USE ONLY **Payment Type:** Order # : _____ Payment Date: _____
 Scholarship/ Amount: _____