



Return both forms along with your payment in full to
Camp Lee, 70 Camp Lee Main Road, Anniston, Alabama 36207.
Make checks payable to Camp Lee and write "Day Camp" and your
child's name on the memo line of the check.

Day Camp Registration Form

Child's Name: _____ Grade Completed: _____ Gender: _____

Parents' name(s) & addresses: _____

_____ E-Mail Address: _____

Day time phone number/cell phone number: _____

Emergency contact information:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Are you a member of First United Methodist Church Anniston? Yes _____ No _____

First United Methodist Church Anniston owns Camp Lee Ministry. Would you like to receive information about FUMC Anniston? Yes _____ No _____

Please check which week(s) your child would like to attend: (Cost is \$80.00 per week)

____ Day Camp 1 Completed K, 1st and 2nd graders June 2 - 6

____ Day Camp 2 Completed 3rd, 4th and 5th graders June 9 - 13

____ Day Camp 3 Completed K, 1st and 2nd graders June 16 - 20

____ Day Camp 4 Completed 3rd, 4th and 5th graders June 23 - 27

____ Day Camp 5 Completed K, 1st and 2nd graders July 7 - 11

____ Day Camp 6 Completed 3rd, 4th and 5th graders July 14 - 18

\$ _____ Amount Enclosed Circle one for Youth T-shirt Size: S M L XL

Are there any days of the session that your child will not attend or will be picked up early? _____

Please indicate if someone other than you will be picking up your child: _____

Your child will not be released to anyone other than you without written consent from you. I hereby give my permission for my child to participate in all activities of the Day Camp Program. I understand that Anniston First United Methodist Church/Camp Lee cannot be held responsible for any accident or injury.

Signature: _____

Date: _____

Medical Release Form

I hereby give permission for any and all medical attention necessary to be administered to my child (name) _____ in the event of accident, injury, sickness, etc., under the direction of either of the person(s) designated below, until such time as I may be contacted. If neither of the person(s) designated below can be contacted, I give permission for treatment of my child as may be required subsequent to a determination made by the appropriate health care professional who is present. This release is effective until revoked, in writing, by me. I also hereby assume responsibility for payment of such treatment.

My name: _____ Phone (H) : _____ (W): _____

My address: _____

City: _____ State: _____ Zip: _____

My insurance company is: _____

My insurance policy number is: _____

In case I cannot be reached, either of the following is designated:

Name: _____ Phone: _____

Name: _____ Phone: _____

My physician: _____ Phone: _____

Physician's address: _____

Known allergies of child: _____

Signature (parent): _____

Parent's name (print): _____

Date: _____