

**ALFRED UNIVERSITY**  
**EQUESTRIAN DAY CAMPS**  
**June 25-28 and July 23-26, 2012**  
**ENROLLMENT FORM**

*The Enrollment Deadlines: **June 15 for first week; July 13 for second week** - Camp Fee: **\$350 per week***

*To be completed by parent or guardian. Your \$350/week payment must accompany this form. If enrolling more than one camper, please use a separate form for each.*

### Camper Information

**In which camp week(s) is the camper enrolling?**    **June 25-28 (English & Western)**    **July 23-26 (Western, only)**

Camper's Name: \_\_\_\_\_ Preferred First Name for Nametag: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street City State Zip

Phone (number to call weekdays, between 8:30 am & 4:30 pm, if we have questions): \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

E-mail (to contact with questions): \_\_\_\_\_ Has camper ever attended this camp before?    Yes    No

Camper's current skill level:    beginner    intermediate    advanced   How many years has camper been riding (if applicable)?: \_\_\_\_\_

Which type of instruction is camper interested in?    English    Western   How many years has camper taken lessons (if any)?: \_\_\_\_\_

### HEALTH HISTORY & EMERGENCY INFORMATION

**Personal Medical History:** Has he/she had any of the following? Please check all that are applicable.

- |   |  |   |                                       |
|---|--|---|---------------------------------------|
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Vision Problems     | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Anemia       |
| <input type="checkbox"/> Chicken Pox      | <input type="checkbox"/> Hay Fever           | <input type="checkbox"/> Malignancy     | <input type="checkbox"/> Hepatitis    |
| <input type="checkbox"/> Scarlet Fever    | <input type="checkbox"/> Measles             | <input type="checkbox"/> Hives          | <input type="checkbox"/> Operations   |
| <input type="checkbox"/> Bronchitis       | <input type="checkbox"/> Ear Infections      | <input type="checkbox"/> Mumps          | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Rheumatic Fever  | <input type="checkbox"/> Heart Problems      | <input type="checkbox"/> Tonsillitis    | _____                                 |
| <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Pneumonia      | _____                                 |
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Emotional Disorders | <input type="checkbox"/> Epilepsy       |                                       |
| <input type="checkbox"/> Jaundice         | <input type="checkbox"/> Mononucleosis       | <input type="checkbox"/> Tuberculosis   |                                       |

**Allergies:** Any allergies    yes    no   If yes, what is he/she allergic to? \_\_\_\_\_

### Emergency Information

Parents'/Guardian's Name(s) \_\_\_\_\_ Work Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

**Please list an additional person to contact in case of an emergency if you cannot be reached:**

Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Home/Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Student's Regular Physician (*primary care provider*): \_\_\_\_\_ Physician's Phone: \_\_\_\_\_

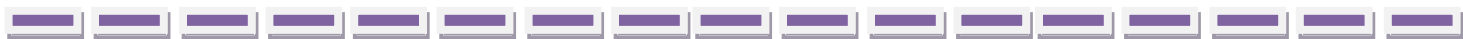
**Health Insurance Information** (If possible, please enclose a photo copy of your insurance card):

Name of person listed as primary insured on the insurance card: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Are there **any special precautions** that must be considered in treating the participant in the case of an emergency (allergies to medicine, diabetes, contact lenses, etc.)?    yes    no   If yes, please explain:

(Please be sure to complete the second page of this form, as well.)



## Permission to Attend Camp, be Photographed, receive Medical Treatment

I, the undersigned parent or guardian, do hereby grant permission for my child (named above) to participate in a summer program at Alfred University.

I give permission for my child to be photographed while participating in camp activities for publicity purposes (some photos will be selected for use on our website and flyers):  yes  no

I do hereby grant permission for my child to receive necessary medical treatment in the event of injury or illness while attending a summer program at Alfred University. I accept responsibility for full payment of such medical treatment. I will not hold the University, the Student Health Center, hospital, and/or their representatives responsible in the exercise of this authority.

\_\_\_\_\_  
**SIGNATURE of parent or guardian**

\_\_\_\_\_  
**PRINT name of parent or guardian**

## Payment

**Please check one of the following:**

My check in the amount of \$\_\_\_\_\_ is enclosed. (Make checks payable to *Alfred University*.)

Please charge to my credit card  VISA  MasterCard  AMEX  Discover

Card Number: \_\_\_\_\_ CVV number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_  
(3 digit code on back of card)

Amount: \$\_\_\_\_\_ Authorized Signature: \_\_\_\_\_

Name of cardholder (please print): \_\_\_\_\_

Address of cardholder: \_\_\_\_\_  
Street

\_\_\_\_\_ Cardholder Phone: \_\_\_\_\_  
City State Zip

## Please send to:

Office of Summer Programs  
Alfred University, 1 Saxon Drive  
Alfred, NY 14802  
FAX: 607-871-2045  
Or, scan and email to [summerpro@alfred.edu](mailto:summerpro@alfred.edu)

(If you fax this form, please call 607-871-2612 to make sure we received it and that it is readable.)

## Thank you!

