School's Out Camp 2024-2025 7-12yrs

Forms received after 12 noon Thursday the week prior to the camp are subject to a $5 late fee.
Payment in full is due at registration. No refunds.

Child's Name: _____ DOB: _____ Age: _____ Sex: M F

Allergies/Special Needs: _____

Pick Up Password: _____ Dietary Restrictions: _____

Parent/Guardian's Name: _____

Phone: (w)_____ (h)_____ (c)_____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

2024 - 2025 Dates Available :

Oct 3 Nov 7, 8 Dec 23, 27, 30

Jan 20 Feb 14, 17 April 18, 21, 22, 23, 24, 25

Please select: _____ HQ Member $45/day _____ Nonmember $55/day

(Child must be an active Member to receive Member pricing)

Regular Camp Day is 9am-3pm

(MUST have a minimum of 5 pre-registered attendees for camp to run)

Please note (next to date(s) needed) if you require the following: BC (Before Care) $10 - AC (After Care) $20

(NO Lunch Option – participants MUST bring Lunch)

_____ _____ _____ _____

_____ _____ _____ _____

Total Balance Due: $_____

I, the parent/guardian of the registrant, a minor, or an adult registrant of legal age, agree that the registrant and I will abide by the rules of HealthQuest of Central Jersey, LLC., its affiliated organization and sponsors. Recognizing the possibility of physical injury associated with leagues and in consideration for HealthQuest of Central Jersey, LLC.,accepting the registrant for its league programs and activities, I hereby release, discharge, and/or otherwise indemnify HealthQuest of Central Jersey, LLC., its officers, coaches, managers, referees, its affiliated organizations and sponsors, their employees, and associated personnel, including the owners of the fields and facilities utilized for the league program, against any claim by or on behalf of the registrant as a result of the registrant's actions. I affirm that the registrant is in sound physical and healthy condition and that the athlete is covered by health/accident insurance secured independently. As parent/guardian or the registrant, I hereby give my permission for the participant of the program to be transported for emergency medical care. I hereby authorize consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions necessary to preserve life, limb or well being of my dependent.

Method of Payment
(PLEASE CIRCLE)

Cash Check Credit Card Member Charge (CC on File)

Account Number _____ Exp Date: _____ CVV: _____

Signature: _____ Date: _____