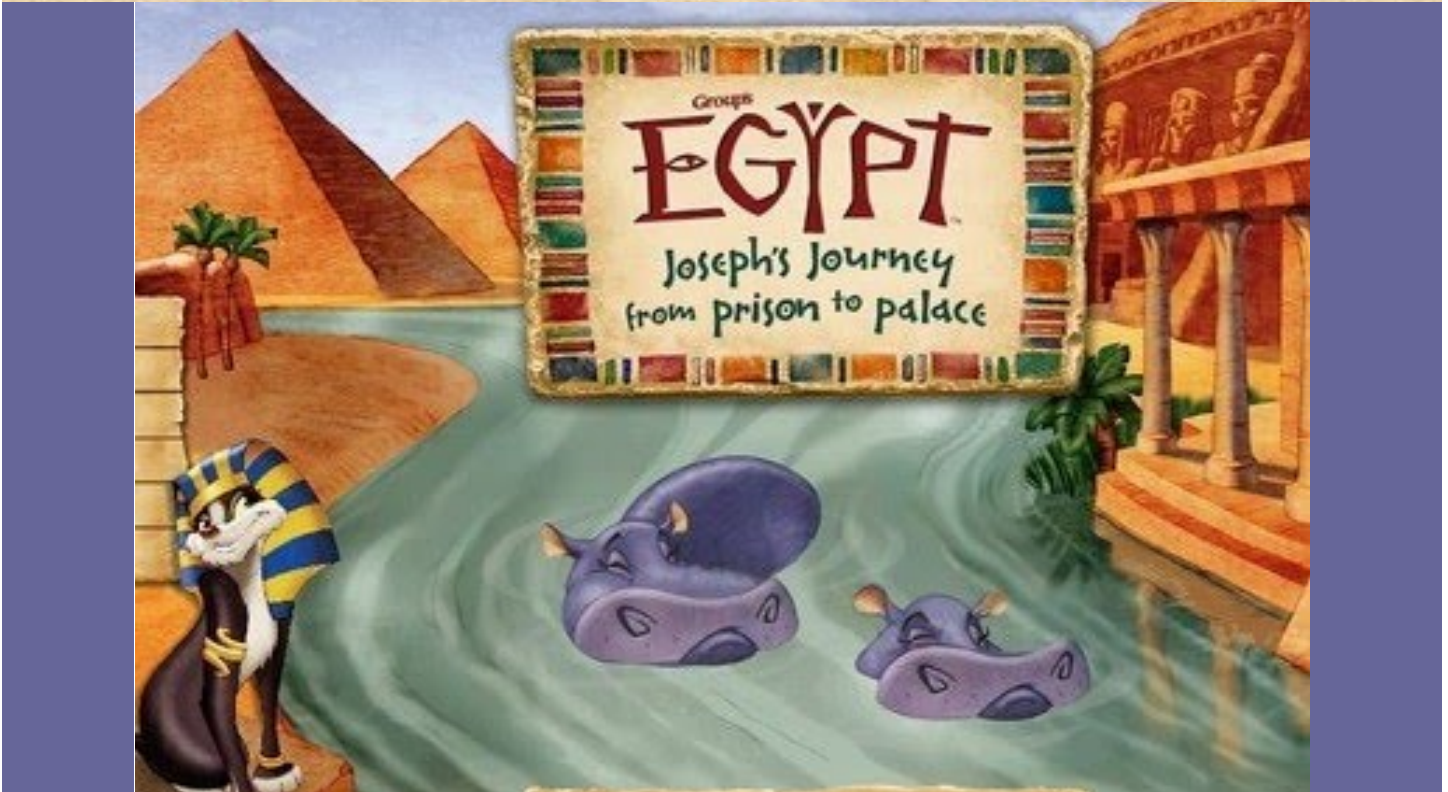


**Coral Gables Congregational Church
United Church of Christ**

**Full -Day
Arts, Outreach and Vacation Bible Camp**



**Monday, August 9 - Friday, August 13
8:30-3:00 p.m.**

For children **entering** Prek-4 through **entering** 6th Grades

Tuition: \$150 per camper for CGCC members
\$175 non member campers

After-care available until 6:00 p.m. - \$50 per camper

(Visa, MasterCard accepted)

Space is limited; register today!

**For more information, contact Megan Korallis, Camp Director
(305) 448-7421, ext. 119 or email: megank@ucc-cgcc.org**



Please return to:
Coral Gables Congregational Church UCC
3010 De Soto Blvd., Coral Gables, FL 33134
Attn.: Megan Korallis
305-448-7421, ext. 119; e-mail MeganK@ucc-cgcc.org

Release Form

I, _____, hereby give permission for my child, _____, male/female (please circle one), age _____, date of birth _____, entering grade _____, to participate in the Arts, Outreach and Vacation Bible Camp at Coral Gables Congregational Church, from August 9 through August 13, 2010, from 8:30 a.m. to 3:00 p.m., at a tuition rate of \$150 per CGCC member camper / \$175 per non-member camper.*

I, _____, hereby give permission for my child, _____, male/female (please circle one), age _____, date of birth _____, entering grade _____, to participate in the Arts, Outreach and Vacation Bible Camp at Coral Gables Congregational Church, from August 9 through August 13, 2010, from 8:30 a.m. to 3:00 p.m., at a tuition rate of \$150 per CGCC member camper / \$175 per non-member camper.*

Parent/Guardian Contact Information

Parent or guardian's name: _____
Church membership: CGCC _____ Other _____ None _____
Address (w/ZIP code): _____
Home phone: _____ Work phone: _____
Beeper: _____ Cell phone: _____ e-mail: _____
If unable to reach, please contact: _____ at _____
Names of person(s) authorized to pick up this child: _____

Emergency Medical Information

Child's physician's name: _____ Phone: _____
Child's medical concerns of which we should be aware: _____

Any known allergies: _____

I authorize medical treatment for my child in the case of accident or illness if parent/guardian cannot be located or an emergency situation should arise.

Parent's signature

Today's date

Payment

If paying by check, make payable to Coral Gables Congregational Church.

Credit Card Information: VISA MasterCard Discover American Express

Card #: _____ Exp. Date: _____

Billing Address: _____ City: _____ Zip: _____

* **Cancellation policy** - CGCC grants refunds according to the following schedule:

- **Full refund of tuition if participant cancels 15 calendar days or more in advance.**
- **Fifty percent (50%) refund if participant cancels three to 14 calendar days in advance.**
- **No refund if participant cancels two days before camp begins or later.**