



FIRST UNITED METHODIST CHURCH OF HURST  
 P.O. Box 1461 • Hurst, TX 76053  
 817.282.7384 • www.fumchurst.org

**OFFICE USE ONLY:**

Medical      Visitor  
 Class Placement

## Music and Arts Camp • July 19–23, 2009

For children entering Kindergarten (or age 5 by 9/1/09) through Sixth Grade

Please fill out one form per child; please register by July 8.

Return to address above (with \$20 Music & Arts Camp fee); attention Erin Halpin

Name: \_\_\_\_\_ Sex: M or F Date of Birth: \_\_\_\_\_

Grade (entering Fall 2009): \_\_\_\_\_ (Must be entering Kindergarten (or age 5 by 9/1/09) through sixth grade)

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Email: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

FUMC Hurst member?

Y or N

If no, regularly attend which church? \_\_\_\_\_

How did you hear about this program? *Circle one:* Church Newspaper

Advertisement    Postcard    Website    Banner on Pipeline    Friend

Name and grade/age of siblings attending camp: \_\_\_\_\_

Who will be picking up your child from camp? \_\_\_\_\_

Other adults authorized to pick up your child. Your child will not be released without a phone call.

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency contact other than parent:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Allergies or other conditions which may limit activity: \_\_\_\_\_

Special Needs? Please describe: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

The undersigned agrees to accept full responsibility for this child's participation in this church related activity and releases First United Methodist Church Hurst, its staff, and volunteers from personal liability for injury or illness resulting under all circumstances, save gross negligence. I hereby give permission that in case of illness or accident requiring a physician's immediate attention, and if I cannot be contacted, medical aid may be administered by a physician or hospital staff designated by the program at my expense.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**For children entering grades 1–6:  
 Please choose electives on the reverse of this form.**

