

# Discovery Day Camps!

Registration/Liability Form

Please complete BOTH SIDES  
One registration form PER CAMPER

Check the camp registering for:

- |   |  |
|---|--|
| <input type="checkbox"/> Students entering 1 <sup>st</sup> or 2 <sup>nd</sup> Grade<br>Wednesdays (9:00 AM-12:00 PM)<br><b>\$10 per student</b>   | <input type="checkbox"/> Students entering 5 <sup>th</sup> or 6 <sup>th</sup> Grade<br>Thursdays (9:00 AM-12:00 PM)<br><b>\$20 per student</b> |
| <input type="checkbox"/> Students entering 3 <sup>rd</sup> or 4 <sup>th</sup> Grade<br>Wednesdays (1:00-4:00 PM)<br><b>\$10 per student</b>   | <input type="checkbox"/> Students entering 7 <sup>th</sup> or 8 <sup>th</sup> Grade<br>Thursdays (1:00-4:00 PM)<br><b>\$20 per student</b>     |
| <input type="checkbox"/> My child would like to participate in the overnight campout (open to students entering 5 <sup>th</sup> grade and older) on July 24 <sup>th</sup> -25 <sup>th</sup> . Details will be sent to interested campers. |  |

Gender: Male   Female

Camper's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Grade completed: \_\_\_\_\_

Address: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Phone during Camp/Cell: \_\_\_\_\_ Email: \_\_\_\_\_

- ☐ Yes, my child may be photographed

Medications: (dose, name, & time)

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Allergies:

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Other needs/concerns:

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**Mail/Return form & fee to: Mitchell County Environmental Education Foundation**

**Attn: Chelsea Ewen**

**18793 Highway 9**

**Osage, Iowa 50461**

Parent Permission:

I hereby give permission for \_\_\_\_\_ to attend this camp program sponsored by Mitchell County Conservation Board and the Mitchell County Environmental Education Foundation. I understand that I will be notified if my child is not respecting others and in the event of severe weather will pick up my child immediately. Conservation staff will supervise the event and provide necessary emergency care. If a serious illness or injury develops and medical and/or hospital care is necessary, I hereby give permission for emergency treatment or surgery as recommended by the attending physician.

\_\_\_\_\_  
Parent/Guardian

Family Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

In case I cannot be reached during the program, please contact: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Please check appropriate response:

- ☐ I will pick up my child at the end of the program
- ☐ My child will be picked up by: \_\_\_\_\_
- ☐ Other: \_\_\_\_\_

\$ Amount Enclosed \_\_\_\_\_

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