

# St. Vincent's One Nineteen Camp Registration

At St. Vincent's One Nineteen, we offer a variety of summer camps for your children. Please read through the camp options below, and select the camps and dates your child will be attending.

## Camp One Nineteen

- Week 1:** Sports around the World- May 29 - June 1 (4-day week)
- Week 2:** Rise of the Minions- June 4 – June 8
- Week 3:** Animals around the World- June 11 – June 15
- Week 4:** Gone Camping- June 18 – June 22
- Week 5:** Sliding through Summer- June 25 – June 29:
- Week 6:** Undercover Superheroes- July 2 – July 3, July 5-July 6 (4-day week)
- Week 7:** At the Fair- July 9 – July 13
- Week 8:** The Great Space Race- July 16 – July 20
- Week 9:** At the Movies- July 23 – July 27
- Week 10:** One Nineteen Olympics (Color Wars Week) July 30 – August 3
- Week 11:** Camp Rewind- August 6 – August 10 (this week held at Supervisor's discretion)

**Cost: Members – \$35/day, \$175/week; Non-members – \$50/day, \$250/week, \$19/day for Thyme to Cook for Kids participants to attend in the morning/afternoon. \$30 non-refundable registration fee.**

## Culinary Boot Camp: A Cooking Academy for Teens

- June 4-8, 8:00 a.m. – 12:30 p.m. (ages 13-18)  
**Cost: \$225/week (includes apron)**

## Thyme to Cook for Kids

- June 11-15: Thyme to Cook, \*7-9 year olds, Savor the South – healthier southern cuisine
  - 8:00 a.m.-12:00 p.m. or  1:00 p.m.-5:00 p.m.
- June 18-22: Thyme to Cook, 10-12 year olds, Savor the South –healthier southern cuisine
  - 8:00 a.m.-12:00 p.m. or  1:00 p.m.-5:00 p.m.
- July 9-13: Thyme to Cook, \*7-9 year olds, Epicurious – for curious cooks
  - 8:00 a.m.-12:00 p.m. or  1:00 p.m.-5:00 p.m.
- July 23-27: Thyme to Cook, 10-12 year olds, Epicurious – for curious cooks
  - 8:00 a.m.-12:00 p.m. or  1:00 p.m.-5:00 p.m.

**Cost: \$225/week (includes apron)**

*\*6 year olds, first grade completed, or at discretion of camp director*

### Please return completed forms to:

St. Vincent's One Nineteen  
c/o Camp Registration  
7191 Cahaba Valley Road  
Birmingham, Alabama 35242

Camp One Nineteen: 205-408-6556  
Cooking Camps: 205-408-6550

# St. Vincent's One Nineteen Children's Programs Registration Form

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Age: \_\_\_\_\_ Birthday: \_\_\_\_\_

Guardian Name: \_\_\_\_\_ Work #: \_\_\_\_\_

DL#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Cell #: \_\_\_\_\_

Member #: \_\_\_\_\_

Guardian Name: \_\_\_\_\_ Work #: \_\_\_\_\_

DL#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Cell #: \_\_\_\_\_

Member #: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Please select your child's t-shirt size:

Youth Sizes:  Small  Medium  Large  X-Large    Adult Sizes:  Small  Medium  Large

Apron size (cooking camp):  Small  Medium  Large

## EMERGENCY CONTACT INFORMATION:

1. Name \_\_\_\_\_ Authorized to pick-up child

Relation to Child: \_\_\_\_\_ Phone #: \_\_\_\_\_

2. Name \_\_\_\_\_ Authorized to pick-up child

Relation to Child: \_\_\_\_\_ Phone #: \_\_\_\_\_

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

Medications currently being taken: \_\_\_\_\_

Allergy/Diet restrictions: \_\_\_\_\_

Physical activities to be restricted: \_\_\_\_\_

To the best of my knowledge, the information in this health form is correct. My child has permission to participate in all Camp activities except those noted above.

In the event of an emergency in which I or the emergency contact person cannot be reached, I \_\_\_\_\_ hereby grant permission to One Nineteen Health and Wellness to give Emergency Medical Services to \_\_\_\_\_ (child's name) by the physician at \_\_\_\_\_ Hospital/Medical Center to secure proper treatment for, and including, but not limited to, injections, anesthesia, or surgery for my child as named herein.

## ADDITIONAL AUTHORIZED PICK-UP LIST:

Please list below additional names of the individuals who are authorized to pick up your child from Camp.

Name: \_\_\_\_\_ Relation to Child: \_\_\_\_\_

Name: \_\_\_\_\_ Relation to Child: \_\_\_\_\_

Name: \_\_\_\_\_ Relation to Child: \_\_\_\_\_

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**FOR OFFICE USE ONLY: Amount Paid: \$** \_\_\_\_\_ **Date:** \_\_\_\_\_

# St. Vincent's One Nineteen Agreement and Release of Liability

Print Name: \_\_\_\_\_ Membership Card Number: \_\_\_\_\_

1. In consideration of gaining access or being allowed to participate in the activities and classes of the St. Vincent's One Nineteen Health and Wellness and to use its facilities, equipment, and machinery in addition to the payment of any fee or charge, I do hereby waive, release and forever discharge St. Vincent's Hospital, Ascension Ventures Corporation d/b/a/ St. Vincent's One Nineteen Health and Wellness, and their respective officers, agents, employees and representatives from any and all responsibilities or liability for injuries or damages resulting from participation in any activities at said facility. I do also hereby release all of those mentioned or others acting on their behalf or in any way arising out of or connected with my participation in any activities of or use of equipment at St. Vincent's One Nineteen Health and Wellness.

Please Initial \_\_\_\_\_

2. I understand and am aware that strength, flexibility, and aerobic exercise including the use of equipment, is a potentially hazardous activity. I also understand that fitness activities involve a risk of injury and even death and that I am voluntarily participating in these activities and using equipment and machinery with knowledge of the dangers involved. I hereby agree to expressly assume and accept any and all risks of injury or death. I understand that my participation in and use of these activities, machines, and equipment is contingent upon my ability to independently, safely and correctly perform exercises. I understand and accept that it is my responsibility to inform the St. Vincent's One Nineteen Health and Wellness staff of significant changes in my health and medical conditions as it relates to exercise.

Please Initial \_\_\_\_\_

3. I do hereby acknowledge that I have been informed of the need for a physician's approval for my participation in any of the activities and programs of St. Vincent's One Nineteen Health and Wellness center or use of equipment or machinery except as hereinafter stated. I also acknowledge that it has been recommended that I have a yearly and more frequent physical examination and consultation with my physician as to physical activity, exercise, and use of exercise and training equipment. So that I might have recommendations concerning these fitness activities and equipment use. I acknowledge that I have either had a physical examination and have been given a physician's permission to participate, or that I have decided to participate in activity and/or use of equipment and machinery without the approval of my physician and do hereby assume all responsibility for my responsibility for my participation and activities, and utilization of equipment and machinery in my activities.

Please Initial \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PARENT/GUARDIAN (Please sign if participant is under 18 years of age)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
DATE

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# AUTHORIZATION FOR PHOTO AND MEDIA RELEASE

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

Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Phone: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

1. I hereby authorize Ascension and its hospitals, affiliates, subsidiaries employees ("Ascension") to photograph, interview, use and publish my photographic or video image, or the photographic or video image of my minor child(ren) \_\_\_\_\_ [Insert name of child or children] or my property.
2. I understand that the photographic or video image, or media interview may be produced and released in any media form, including, but not limited to, internet, newspaper, television, radio and/or marketing materials, in whole or in part, with such alterations and changes as Ascension desires, and that the images or interview may appear separately or with my name or the name(s) of my minor child(ren) included in this Authorization.
3. I understand that the purpose of the use or release of the images and media interview will be for education, marketing or public relations purposes.
4. The use or release of the images or media interview may be made to the public through education, marketing and public relations efforts for commercial or noncommercial publications, exhibits, and/or on the intranet and internet.
5. I agree that all pictures, reproductions, negatives, tapes of any kind relating to the images, and materials relating to interviews are, and shall remain, the property of Ascension and its agents to whom permission has been granted. If I should receive any print, negative or other copy thereof, I shall not authorize its use by anyone else.
6. I agree that no advertisement, photograph or other material need be submitted to me for approval, and Ascension shall be without liability to me for any distortion or illusionary effect resulting from the publication of my video, picture, portrait, likeness, or comments.
7. I understand that my signing this Authorization does not obligate Ascension to make use of any photographic or video images or media interviews.
8. I understand that this Authorization can be revoked by me at any time by submitting a written request to Ascension Communications, 101 S. Hanley, Suite 1100, St. Louis, MO 63105.
9. I understand that my revocation will not apply in those instances in which Ascension has acted upon this Authorization prior to the revocation being received by Ascension.
10. I understand that the information released pursuant to this Authorization may be subject to re-disclosure and no longer protected by state and federal privacy laws.
11. I hereby release and discharge Ascension from any and all claims, actions, and demands arising out of or in connection with the use of any photographic or video images or media interviews without limitation.
12. I understand that Ascension cannot require me to sign this Authorization as a condition of providing treatment to me or my minor children or obtaining payment for treatment.
13. I understand that my signing this Authorization is voluntary, not a requirement of my employment at Ascension, and that I will not face any repercussions on my employment status if I so choose not to sign this Authorization.
14. This Authorization will expire on \_\_\_\_\_. If no specific date is indicated, this Authorization will expire in ten (10) years.

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**Patient Signature/Authorized Representative:**

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**Date signed:**

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**Relationship:**

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**Witness:**

*A copy of this Authorization must be presented to the person signing the Authorization.*

