Program Application

July 21–Aug 1, 2025, 9:00am–3:00pm | Camp fee: $200 | Application due by 7/03/25 or until camp is full

Name: _____ Age: ____ Birthday: _____ Adult T-Shirt Size:_____

Home Address: _____

Phone (Home/Parent/Guardian's Work/Cell): _____

Email: _____

Can you attend EVERY DAY of the 2-week camp? ☐ YES ☐ NO

Can you arrive at the medical center every day at 9:00am and be picked up promptly at 3:00pm? ☐ YES ☐ NO

School: _____ Grade in School: _____

Grade average (please circle): A (Excellent) B (Good) C (Satisfactory) D (Needs Improvement)

What is your favorite subject in school? (ex: math, science, art, etc.) _____

What are your hobbies/interests? (ex: sports, music, etc.) _____

_____

How did you find out about Medical Adventure Camp? _____

What are you hoping to experience during Medical Adventure Camp? (Attach paper if needed.)

_____

_____

_____

Required Parent/Guardian Permission Slip on Other Side*Applications Due by 7/03/25

Applications are accepted on a first-come, first-served basis until camp is full. Payment in cash or check (no credit cards) is due at time of application to guarantee your space. Make checks payable to Salinas Valley Health Service League. Please submit completed application and payment to Salinas Valley Health, Volunteer Services Department, 420 E. Romie Lane, Suite C, Salinas, CA 93901.

A limited number of scholarships are available. Please contact Volunteer Services for details at **831-755-0772** or volunteer@SalinasValleyHealth.com.

Salinas Valley HEALTH

MEDICAL ADVENTURE CAMP

Permission to Participate
Waiver & Release
Consent to Photograph

I, _____ , give permission for my child, _____ , to attend Medical Adventure Day Camp at Salinas Valley Health Medical Center and to participate in all Medical Adventure Camp activities and field trips.

I give permission to have my child transported from the basic camp activities for any special camp-related activities.

In the event of illness or injury, I do hereby authorize and consent to any X-ray, examination, anesthetic, medical, surgical, or dental diagnosis or treatment and medical center care as considered necessary and is to be rendered under the general or special supervision of any medical or emergency room staff licensed under the provision of the Medical Practice Act. It is understood that this authorization is given in advance of any specific diagnosis, treatment or medical center care being required, but is given to provide consent to such care when the foregoing licensed medical center physician in their best judgment deems it advisable. I understand that the medical center staff shall attempt to contact me prior to rendering treatment to my child; however, treatment will not be withheld if I cannot be reached. I hereby authorize the medical center to surrender physical custody of my child to the individual who presented the child for treatment upon completion of the treatment if I am not present on my child's release. Consent shall remain in effect from July 21 - Aug 1, 2025.

I also authorize Salinas Valley Health to photograph or permit other persons to photograph my child and use the negatives or prints prepared from such photographs for such purposes as Salinas Valley Health may deem appropriate. I hereby waive any right to compensation for such uses. (The term "photograph" shall mean motion picture or still photography in any format, as well as videotape, video disc, and any other mechanical means of recording and reproducing images.)

I do hereby, for myself, my heirs, my executors, and assignees waive, release, and forever discharge any and all rights and claims for damages/lost property I may have or which may accrue to me against Salinas Valley Health, and any involved municipalities or other entities, or any subsidiary or political subdivision thereof its or their respective officers, agents, representatives, successors, assignees, and sponsors for any and all damages which may be sustained and suffered by me in connection with the Medical Adventure Camp.

Date: _____ Parent/Guardian Signature: _____

Parent/Guardian Name (please print): _____

Address: _____

Phone: Home _____ Business _____ Cell/Pager _____

Salinas Valley HEALTH

MEDICAL ADVENTURE CAMP