



Summer Camp Registration 2025

620 W. Martintown Road | North Augusta, SC 29841
learningcenter@victorybc.com | 803-522-0551
Mrs. Bethany Stafford, Director | CT Townsend, Pastor



Registration Information

Child's Name:	Child's Birthdate:
Home Address:	
Mother/Guardian Name:	Cell Phone:
Email:	
Father/Guardian Name:	Cell Phone:
Email:	

Week(s) Registered

<input type="checkbox"/> ALL 8 WEEKS!	<input type="checkbox"/> June 16 - June 20	<input type="checkbox"/> July 7 - July 11	<input type="checkbox"/> July 28 - August 1
<input type="checkbox"/> June 2 - June 6	<input type="checkbox"/> June 23 - June 27	*No Camp: July 14 - July 18	
<input type="checkbox"/> June 9 - June 13	<input type="checkbox"/> June 30 - July 3	<input type="checkbox"/> July 21 - July 25	

Authorization

Parent/Guardian Signature:	
Printed Name:	Date:

Billing and Enrollment Details

WEEKLY TUITION	\$200
REGISTRATION FEE	\$100
WRAP AROUND CARE	AM ONLY - \$10/WEEK PM ONLY - \$20/WEEK AM & PM - \$30/WEEK

Payment is due the Friday before the start of each new week.
Registration Fee is non-refundable and due at time of enrollment to reserve your child's spot. Cancellations will not be refunded.

Office Only

☐ Registration Fee Collected Date: _____



SUMMER CAMP MEDICAL HISTORY FORM & RELEASE

620 W. Martintown Road | North Augusta, SC 29841
learningcenter@victorybc.com | 803-522-0551
Mrs. Bethany Stafford, Director | CT Townsend, Pastor



Camper Information

Child's Name:		Child's Birthdate:	
Home Address:			
Mother/Guardian Name:		Cell Phone:	
Email:			
Father/Guardian Name:		Cell Phone:	
Email:			
Who to notify in not available			
Name:	Relationship	Phone	

HEALTH HISTORY

The following information must be filled in by the parent/guardian. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to Victory Early Learning Center upon participant's arrival in camp.

ALLERGIES List all known medical and food allergies. Only list food allergies if reactions are severe or fatal.

--

SPECIAL DIET If your child requires a doctor prescribed diet, please indicate below.

--

MEDICATIONS BEING TAKEN Please list ALL medications (including over the counter or non-prescription drugs) taken routinely.

☐ This person takes NO medications on a routine basis.

☐ This person takes medications as follows:

Medication:	Dosage:	Specific time to take:
Medication:	Dosage:	Specific time to take:



SUMMER CAMP MEDICAL HISTORY FORM & RELEASE

620 W. Martintown Road | North Augusta, SC 29841
learningcenter@victorybc.com | 803-522-0551
Mrs. Bethany Stafford, Director | CT Townsend, Pastor



Child's Name:	Child's Birthdate:
---------------	--------------------

Provide any additional information about the participant's behavior and physical, emotional, or mental health about which we should be aware.

Please give most recent immunization dates for the following

Tetanus		Hepatitis B		Polio	
MMR		Polio		DPT Series	
Varicella (chickenpox) (optional)					

Explain any restrictions of participation in full camp program/activities

Physician Information

Name of participant's pediatrician or family doctor:	
Office Phone:	Address:

Insurance Information

Insurance Company:	Policy # / Group #:
Insurance Address:	
Name of Insured Relationship to participant	

Acknowledgement

I confirm that this health history is correct and complete as far as I know. I agree to notify the Center if any change occurs in my child's medical condition before arriving at camp. The person herein described has permission to engage in all camp activities except as noted above. I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment. I give permission to the camp to arrange necessary related transportation for my child. I agree to the release of any records necessary for insurance purposes. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization for the person named above. I hereby waive and release Victory Early Learning Center and its staff from any and all liability for any injury or illness incurred at camp. Final permission is given to use any pictures of the above mentioned minor for promotional purposes.

Parent/Guardian Signature:	
Printed Name:	Date: