Sports Vision Camp Registration

Last Name First Name Preferred Name

Address City State Zip

Date of Birth Entering Grade Sports Played

Parents Best Phone Number

Email (best way for us to confirm registration)

Emergency Contact (other than parent) Phone Number

Please indicate which camp you prefer:

_______Session 1 **(June 5, 12, 19, 26)** 9:00-10:00am (Grades 3-4) 10:15 -11:15am (Grades 5-6)

_______Session 2 **(July 10, 17, 24, 31)** 9:00-10:00am (Grades 3-4) 10:15- 11:15am (Grades 5-6)

A little more info on your athlete…

Has your child had a previous eye health and vision exam? Y N

Does s/he wear glasses or contact lenses? Y N

Does s/he have a history of any other eye conditions? (eye turn, reduced vision, etc.) Y N

If yes, please explain ____

Does s/he have a history of seizures or other medical concerns? Y N

If yes, please explain ____

I acknowledge that Sports Vision Camp is a 4-week recreational program to help with visual skills important for athletics. The nature of the camp will be fun and active with a little bit of competition. I understand Visions Eye Care and Vision Therapy Center will not be held responsible for any injuries that may occur while my child participates in the Sports Vision Camp. I understand that it is not a substitute for a comprehensive eye health and vision examination or a comprehensive vision therapy program.

____ ___________________________

Parent Signature **Date**

Please return this form along with $85 payment either in person, via mail or fax (please phone in credit/debit card payment if fax) to:

Visions Therapy Center
6144 S Lyncrest Ave
Sioux Falls, SD 57108
Phone (605) 271-7100; fax (605) 271-7781

You will receive confirmation of registration via email.