



**Green Acres Weekday Preschool**  
2085 Barnett Shoals Road  
Athens, GA 30605  
(706)549-1925 Fax: (706)543-5166  
Website: www.gabcweekdaypreschool.com

**Summer Camp Registration Form**

Child's Name: \_\_\_\_\_ Birthday: \_\_\_\_\_  
(Last) (First) (Middle) Mo. Day Yr.

Name Child is called: \_\_\_\_\_ SEX: \_\_\_\_\_ AGE: \_\_\_\_\_

Address: \_\_\_\_\_ PHONE: \_\_\_\_\_  
(STREET) (CITY) (ZIP)

E-mail address: \_\_\_\_\_ ALLERGIES\*: \_\_\_\_\_

Date of application: \_\_\_\_\_

Please select one of the following classes:

\_\_\_\_\_ completed 1's class \_\_\_\_\_ completed 4's class (Pre-K)  
\_\_\_\_\_ completed 2's class \_\_\_\_\_ completed K  
\_\_\_\_\_ completed 3's class

Please select the session(s) that you would like to attend:

\_\_\_\_\_ June 5-9  
\_\_\_\_\_ July 10-14

Mother's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Cell: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Cell: \_\_\_\_\_

Contact person and authorized pick-up to call who would assume responsibility for your child in an emergency if the school is unable to contact parents: (use as many lines as needed)

<u>Name:</u>	<u>Relation:</u>	<u>Phone:</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

**Child's Health Record**

Child's Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Hospital Preference: \_\_\_\_\_

All students must provide an updated immunization record signed by a physician.

\_\_\_\_\_  
PARENT'S SIGNATURE

\*If an allergen is listed, you will need to fill out an allergen form that will be sent to you upon receipt of application.

Deposit amount paid: \_\_\_\_\_ Check # \_\_\_\_\_ or Online Confirmation # \_\_\_\_\_