

## **Preschool Summer Camp Application 2021**



			Last Name:
<b>Date of Birth:</b> /_	/ Ch	nild's Age	
Parents or Guardian	's Name(s): _		
Address:			Home Phone #:
Mother's Work Phor	1e #		Father's Work Phone#:
Mother's Cell#			Father's Cell Phone#:
Person(s) authorized t Name:		•	cy Contacts: (Person must show picture I.D.) Phone#:
Name:		_ Relationship:	Phone#:
Name:		_ Relationship:	Phone#:
Student lives with: Fa	ather _ Mo	ther Step-Pare	ents Foster Legal Guardian Other
		•	•
Primary Language: 🤈	□English □Si	panish □Otner:	
		r taking any medi	ication(s)?   Yes   No
Is your child under m	nedical care o	<b>.</b>	
Is your child under m	nedical care o	g conditions that	your child has and indicate if medication needs to be dispens
Is your child under m If yes, please check al at school?   Bee Sting Allergy	nedical care on all the following Epi-pen	g conditions that	your child has and indicate if medication needs to be dispens  □ Other Allergies:
Is your child under m  If yes, please check al at school?  □ Bee Sting Allergy □ Asthma	nedical care of all the following Epi-pen Inhaler	g conditions that	your child has and indicate if medication needs to be dispens  Other Allergies:  Special Needs / Disability:
Is your child under m  If yes, please check al at school?  □ Bee Sting Allergy  □ Asthma  □ Diabetes	medical care of all the following Epi-pen Inhaler Insulin	g conditions that y  □ Yes □ No □ Yes □ No □ Yes □ No	your child has and indicate if medication needs to be dispens  Other Allergies:  Special Needs / Disability:
Is your child under m  If yes, please check al at school?  □ Bee Sting Allergy □ Asthma	nedical care of all the following Epi-pen Inhaler	g conditions that	your child has and indicate if medication needs to be dispens  Other Allergies:  Special Needs / Disability:
Is your child under m  If yes, please check al at school?  □ Bee Sting Allergy  □ Asthma  □ Diabetes	medical care of all the following Epi-pen Inhaler Insulin Glasses	g conditions that	your child has and indicate if medication needs to be dispens  Other Allergies:  Special Needs / Disability:
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Is your child under m  If yes, please check al at school?  Bee Sting Allergy Asthma Diabetes Vision / Hearing  Family Health Care:  Medicare: Yes  Photo Permission: Does the NVCDC pro-	medical care of all the following Epi-pen Inhaler Insulin Glasses  Physician No Health	g conditions that	your child has and indicate if medication needs to be dispens  Other Allergies: Special Needs / Disability: Other: Phone #:
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Is your child under m  If yes, please check al at school?  Bee Sting Allergy  Asthma Diabetes Vision / Hearing  Family Health Care:  Medicare: Yes  Photo Permission:  Does the NVCDC proyes: No: Feeding Program Enro  Parent or Guardian S  For Office Use Only	medical care of all the following Epi-pen Inhaler Insulin Glasses Physician No Health ogram have percollment:Free Signature:	g conditions that	your child has and indicate if medication needs to be dispensed of the composition of the composition of your child in educational or promotional materials.    Paid
Is your child under m  If yes, please check al at school?  Bee Sting Allergy  Asthma Diabetes Vision / Hearing  Family Health Care:  Medicare: Yes  Photo Permission:  Does the NVCDC proyes: No: Feeding Program Enro  Parent or Guardian S  For Office Use Only Enroll Date/Drop-In D	medical care of all the following Epi-pen Inhaler Insulin Glasses Physician No Health ogram have percollment:Free Signature:	g conditions that	your child has and indicate if medication needs to be dispensed of the composition of the