Half Day & Full Day Summer Camp Registration Form 2025

Child:

Last Name: _____ First Name: (Name to be Used) _____

Male/Female _____ Age: _____ Date of Birth: (Month/Day/Year)_____

School Grade Fall 2025: _____ School Name: _____

CAMP:

AM Camp_____ PM Camp_____ Full Day: _____

Extended Care: AM only _____ PM Only _____ Both AM + PM _____ Summer Tutoring after 3:30 pm _____

Camp Options:

Camp Weeks: Week 1: _____ Week 2:_____ Week 3:_____ Week 4:_____
(Please Checkmark) Week 5:_____ Week 6:_____ Week 7:_____ Week 8:_____

Family Physician:

Parent/Guardian☹ (Primary contact)

Surname:_____First Name:_____

Marital Status: _____Home Phone:_____Cell Phone:_____

Address:_____

Email:_____ Occupation:_____

Business Phone:_____ Employment Address::_____

Parent/Guardian (Secondary Contact)

Surname:_____First Name:_____

Marital Status:_____Home Phone:_____Cell Phone:_____

Address:_____

Email:_____ Occupation:_____

Business Phone:_____ Employment Address:_____

Do Both Parents Have Access to the Child? **Yes** **No**
(Court Orders Must Accompany Application)

Do We Have Your Permission to Photograph Your Child? **Yes** **No**

EMERGENCY CONTACT INFORMATION: (Other than Parents)

1. Name:_____Relationship:_____

   Home Phone:_____Business Phone_____

2. Name:_____Relationship:_____

   Home Phone: _____Business Phone: _____

Brothers, Sisters or Others living in the home that has permission to pick up your Child:

Name(s):_____Relationship:_____

Name(s):_____Relationship:_____

Medical History

Previous Illnesses (Please Checkmark any that your child has had)

☐ German Measles	☐ Whooping cough	☐ Poliomyelitis
☐ Measles	☐ Eczema	☐ Reaction to Bites/Stings
☐ Tuberculosis	☐ Scarlet Fever	☐ Rheumatic Fever
☐ Asthma	☐ Mumps	☐ Other (Please describe)_____
☐ Chicken Pox	☐ Diphtheria	

Medical Conditions & History of Communicable Diseases:

Allergies: _____Epi Pen Needed? _____

Other:_____

Special Diet: (i.e. Diabetic, Foods which are non-permissible to due to Religious Reasons)

_____

_____

Autism/ADHD _____Other Behavior issues_____

Communicable Diseases: _____

******In the event of an emergency where an Ambulance is called and you or your Emergency Contacts are unable to arrive in time, a Camp Staff Member will accompany your child to the hospital.******

Mother Signature:

_____Date:_____(required)

Father Sigunature

:_____Date:_____(Required0

OFFICE USE ONLY:

Date of Registration:_____Fee Paid in Full_____Camp Weeks:_____