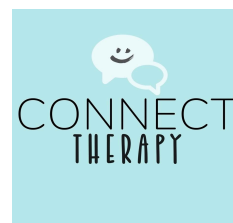


11921 S. Dixie Hwy. Suite 207 Pinecrest, FL 33156

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## CAMP CONNECT APPLICATION SUMMER 2025

### Camper

First \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last \_\_\_\_\_ Gender: Male \_\_\_ Female \_\_\_

School Name \_\_\_\_\_ Grade \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Street Address \_\_\_\_\_

Town/City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_ Child's Main Contact# \_\_\_\_\_

Child lives with: \_\_\_\_\_

Person responsible for payment \_\_\_\_\_

### Parent/Guardian - Contact Information

*Parent/Guardian #1* First \_\_\_\_\_ Last \_\_\_\_\_

Street Address (same as above) \_\_\_\_\_

Town/City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Email \_\_\_\_\_

*Parent/Guardian #2* First \_\_\_\_\_ Last \_\_\_\_\_

Street Address (same as above) \_\_\_\_\_

Town/City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Email \_\_\_\_\_

### Emergency Contact Information – Alternate Pickup/Release

#### *Emergency Contact #1*

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Main Phone \_\_\_\_\_

Email \_\_\_\_\_ Relation to child \_\_\_\_\_

#### *Emergency Contact #2*

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Main Phone \_\_\_\_\_

Email \_\_\_\_\_ Relation to child \_\_\_\_\_

Please list those people including in addition to parents/guardians who are permitted to pick up your child:

1: \_\_\_\_\_ 2: \_\_\_\_\_ 3: \_\_\_\_\_

### Medical Release Information

#### *Insurance Information*

Policy Number \_\_\_\_\_ Name of Health Insurance Provider \_\_\_\_\_

Primary Physician \_\_\_\_\_ Address \_\_\_\_\_

Phone \_\_\_\_\_ Hospital Preference \_\_\_\_\_

Please list any medical problems, including any requiring maintenance medication (i.e. Diabetic, Asthma, Seizures).

#### Medical Problem

#### Required treatment

#### Should paramedic be called?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Yes/No  
Yes/No  
Yes/No

Is your child presently being treated for an injury or sickness, or taking any form of medication for any reason?

Yes \_\_\_ No \_\_\_ If yes, explain: \_\_\_\_\_

(cont. to next page)

## Connect Therapy Services

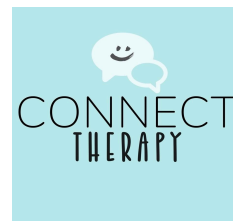
Speech & Language Disorders - Reading Disabilities - Diagnostics & Intervention

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Is your child allergic to any type of food or medication?

Yes\_\_ No\_\_ If yes, explain:\_\_\_\_\_

Does your child require a special diet?

Yes\_\_ No\_\_ If yes, explain:\_\_\_\_\_

The purpose of the above listed information is to ensure that medical personnel have details of any medical problem which may interfere with or alter treatment.

#### **MINI CAMP TUITION & PAYMENT:**

##### **Registration Fee:**

A \$120 registration non-refundable fee is due at the time of camp registration. This will include a camp t-shirt, materials, snacks and drinks. **Summer camp tuition fee is due by April 30th, either by cash, check, Zelle or credit card payment to guarantee a spot. Limited spots will be available.** If a camper's tuition is not paid they will not be able to attend camp. The financially responsible party signing this form understands and agrees to follow the Tuition Payment and Fees Policy.

##### **Please select from the following summer session options:**

##### **Reading Intensive Summer Excel (R.I.S.E.) - Mondays & Wednesdays 8:30am-12:30pm**

- ☐ Full 6 weeks 6/30/25-8/7/24 \*\$50 Discount
- ☐ Week of 6/30/25 - \$315
- ☐ Week of 7/7/25 - \$315
- ☐ Week of 7/14/25 - \$315
- ☐ Week of 7/21/25 - \$315
- ☐ Week of 7/28/25 - \$315
- ☐ Week of 8/4/25 - \$315

**Camp Tuition SubTotal:\_\_\_\_\_**

##### **Reading Intensive Summer Excel (R.I.S.E.) - Tuesdays & Thursdays 8:30am-12:30pm**

- ☐ Full 6 weeks 6/30/25-8/7/24 \*\$50 Discount
- ☐ Week of 6/30/25 - \$315
- ☐ Week of 7/7/25 - \$315
- ☐ Week of 7/14/25 - \$315
- ☐ Week of 7/21/25 - \$315
- ☐ Week of 7/28/25 - \$315
- ☐ Week of 8/4/25 - \$315

**Camp Tuition SubTotal:\_\_\_\_\_**

##### **R.I.S.E.Full Week - Mondays - Thursdays 8:30am-12:30pm**

- ☐ Full 6 weeks 6/30/25-8/7/24 \*\$100 Discount
- ☐ Week of 6/30/25 - \$550
- ☐ Week of 7/7/25 - \$550
- ☐ Week of 7/14/25 - \$550
- ☐ Week of 7/21/25 - \$550
- ☐ Week of 7/28/25 - \$550
- ☐ Week of 8/4/25 - \$550

**Camp Tuition SubTotal:\_\_\_\_\_**

### **Connect Therapy Services**

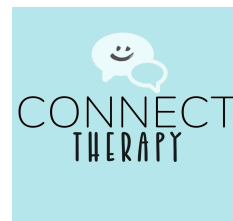
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## Terms of Agreement

### Photo Release

I hereby give permission for my child to be photographed during the Connect Therapy Summer Program. I understand the photos will be used to keep a journal of activities, to share during powerpoint presentations and/or reports and for promotional purposes including flyers, brochures, newspapers and on the internet. I understand that although my child's photograph may be used for advertising, his or her identity will not be disclosed, I do not expect compensation and that all photos are the property of Connect Therapy Services LLC. and its affiliates.

Parent's/Guardian's Initials \_\_\_\_\_

Connect Therapy Services LLC. and its co-organizers are not responsible for lost or damaged personal property. All scheduled events are subject to change. I understand that no fees will be refunded or transferred unless a child is unable to participate due to an accident or illness per physician orders. Children's photos and quotes may be used for publicity purposes. In case of an emergency, and if a family physician cannot be reached, I hereby authorize my child to be treated by Certified Emergency Personnel (i.e. EMT, First Responder, and/or Physician).

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Parent/Guardian: \_\_\_\_\_

Director Signature: \_\_\_\_\_

## Participation Consent Form

(REQUIRED)

I, the undersigned\*, hereby release discharge, indemnify, hold harmless and defend Connect Therapy Services LLC., its officers and employees from any and all liability (claims, demands, losses, causes of action, suits, judgements) of any kind that I or my family may have against Connect Therapy Services LLC. due to death, personal injury or illness, loss or damage to property, or future causes that occur during the 2024 Camp Connect Program. In the event of any medical emergency, I authorize and consent for Connect Therapy Services LLC. to act on behalf for medical care deemed necessary for the participant.

Name of Participant \_\_\_\_\_ D.O.B. \_\_\_\_\_

Name of Parent \_\_\_\_\_ Email \_\_\_\_\_

Medical Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone Number \_\_\_\_\_

\*Parent Signature \_\_\_\_\_

Contact Number \_\_\_\_\_

Date \_\_\_\_\_

---

For office use:

Application received on \_\_\_\_\_

Deposit received on \_\_\_\_\_

Camp Tuition received on \_\_\_\_\_

## Connect Therapy Services

Speech & Language Disorders - Reading Disabilities - Diagnostics & Intervention