



Full Day Summer Camp Registration Form 2017

Child:

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

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

School Grade Fall 2017: _____ School Name: _____

Camp Options:

Week 1: July 10 – Let's Work Together!!

Week 5: August 8 – Minds Under Construction??

Week 2: July 17 – Game Plan??

Week 6: August 14 – Let's Get Creative!!

Week 3: July 24 – Mix It Up!!

Week 7: August 21 – Physically Fit!!

Week 4: July 31 – What's Under Your Feet

Week 8: August 28 – Water Works!!

Camp Weeks: Week 1: _____ Week 2: _____ Week 3: _____ Week 4: _____

(Please Checkmark) Week 5: _____ Week 6: _____ Week 7: _____ Week 8: _____

Family Physician:

Name: _____ Phone Number: _____

Address: _____

Parent/Guardian:

Surname: _____ First Name: _____

Marital Status: _____ Home Phone: _____ Cell Phone: _____

Address: _____

Email: _____ Occupation: _____

Business Phone: _____ Employment Address: _____

Parent/Guardian:

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)

- | | | |
|---|---|--|
| <input type="checkbox"/> German Measles | <input type="checkbox"/> Whooping cough | <input type="checkbox"/> Poliomyelitis |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Eczema | <input type="checkbox"/> Reaction to Bites/Stings |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Mumps | <input type="checkbox"/> Other (Please describe) _____ |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> 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 :)

Behaviour 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 Learna Camp Staff Member will accompany your child to the hospital.*****

Parent Signature: _____ **Date:** _____

Parent Signature: _____ **Date:** _____

OFFICE USE ONLY:

Date of Registration: _____ Fee Paid in Full _____ Camp Dates: _____