

REGISTRATION FORM

Only One child per registration form, please.
2019 Summer Day Camp

Summer Day Camp



| | | | | |
|------------------------------------|------------------|------------------------------------|-------------------|-----|
| Child's LAST Name | First Name | Middle Name | Nickname, if any. | |
| Grade in Fall 2018 | School Attending | Birth Date | Age | Sex |
| Parent/Guardian | | Parent/Guardian | | |
| Address | | Address | | |
| City/State/Zip | | City/State/Zip | | |
| Day Phone (Work or Cell?) | Home Phone | Day Phone (Work or Cell?) | Home Phone | |
| Email Address | | Email Address | | |
| Name of Workplace/Complete Address | | Name of Workplace/Complete Address | | |

Arrival/Departure:

My child's arrival and departure from day camp is as follows: _____ (Regular hours 8:30 am – 4:30 pm).

Campers arriving prior to 8:25 a.m. or leaving after 4:30 p.m. Arrival Time: _____ Departure Time: _____

These campers will be required to pay \$3 per day or \$10.00 per week for each extension (a.m. or p.m.) and prompt pick-up is required or additional fees will be assessed.

Individuals authorized to pick up my child (other than registered parents) are:

Any changes to authorized pick up list must be made in writing to The Salvation Army Day Camp Director.
Authorized pick up persons will be asked to present photo id.

| Name | Day Phone | Complete Address | Relationship to Child |
|----------|-----------|------------------|-----------------------|
| 1. _____ | | | |
| 2. _____ | | | |

I will _____ I will not _____ allow members of The Salvation Army staff to apply Sun Block and/or Pure Aloe Vera gel I have provided, on my child if needed. Lotion will be applied in the presence of others and only to exposed areas.

By signing, I acknowledge The Salvation Army is not responsible for lost, stolen, or damaged personal articles. I also acknowledge I am giving permission to use any video or photographs of my child for future promotions.

Parent/Guardian Signature _____ Date _____

DATE RECEIVED: _____ DEPOSIT PAID: _____ DATE CONFIRMED: _____

Health History and Emergency Contacts for: _____ (child's name)

EMERGENCY CONTACT INFORMATION:

A minimum of two emergency contacts other than parents are required. Emergency contacts must be at least 18 years old and be available at the listed number during day camp hours.

| | | | | |
|--------------------------------------|---------------------------|---------------------------|--------------------------------|---|
| _____ Name of Emergency Contact 1 | _____ Day Phone Number | _____ Complete Address | _____ Relationship to child | Auth. Pickup <input type="checkbox"/> |
| _____ Name of Emergency Contact 2 | _____ Day Phone Number | _____ Complete Address | _____ Relationship to child | Auth. Pickup <input type="checkbox"/> |

PHYSICIAN/MEDICAL FACILITY INFORMATION

| | | |
|----------------------------|---|-----------------------|
| _____ Name of Physician | _____ Name and Address of Medical Facility | _____ Phone Number |
|----------------------------|---|-----------------------|

SPECIAL HEALTH INFORMATION (Be specific)

Check any special medical condition that your child may have:

- ☐ No specific medical condition
- ☐ Asthma
- ☐ Diabetes
- ☐ Epilepsy/Seizure Disorder
- ☐ Gastrointestinal or feeding concerns including special diet and supplements
- ☐ Cerebral Palsy/Motor Disorder
- ☐ Emotional/Behavior Disorder including ADD or ADHD or other Mental Health concerns or diagnosis –
Please Specify: _____
- ☐ Other condition(s) requiring special care –
Please Specify: _____
- ☐ Food Allergies –
Please Specify: _____
- ☐ Non-food Allergies –
Please Specify: _____

IMMUNIZATIONS ARE CURRENT _____ Yes _____ NO – what is lacking _____

My Child may/will required medications to be taken during camp hours YES _____ NO _____

*****If yes please complete Form 4 – Medical Release Form

Other information or special instructions:

Continue on separate sheet if needed.

In the event my child becomes ill or injured, I understand every effort will be made to reach me or an emergency contact person on file. I agree that my insurance company or I will assume financial responsibility for any hospital visits or medical treatment. I give consent for The Salvation Army to act on my behalf to obtain emergency care and treatment if it is deemed necessary.

Parent/Guardian
Signature _____ Date _____