

Summer 2019 Registration Form



Last Name: _____

<input type="checkbox"/> Full Day Camp 9-4 <input type="checkbox"/> Half Day Camp 9-1 <input type="checkbox"/> Early Drop Off 8:00am M T W TH F
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PARENTS NAME: _____ EMAIL ADDRESS: _____

STREET: _____ CITY _____ STATE: _____ ZIP _____

PHONE# _____ CELL# _____ EMERGENCY CONTACT AND PHONE # _____

1ST CHILD: _____ AGE: _____ M _____ /F _____ DOB _____ program _____ cost _____ week

2ND CHILD: _____ AGE _____ M _____ /F _____ DOB _____ program _____ cost _____ week

3RD CHILD: _____ AGE _____ M _____ /F _____ DOB _____ program _____ cost _____ week

4TH CHILD: _____ AGE _____ M _____ /F _____ DOB _____ program _____ cost _____ week

NAME AND PHONE # OF PERSON PAYING IF DIFFERENT FROM ABOVE: _____

ANY LIMITATIONS WE SHOULD KNOW ABOUT: _____

INSURANCE CO. _____ DR. _____ PHONE # _____

HOW DID YOU HEAR ABOUT US? _____ **ALLERGIES:** _____

Name of person dropping off or picking up if different from above:

Drop off: _____ days: _____

Pick up: _____ days: _____

- Immunization records
- Current Physical
- Medical Consent/Plan of Action

PROGRAM	TUITION	TOTAL PD.	DATE PD.	FORM OF PAYMENT
SESSION 1 June 24-28)	_____	_____	_____	_____
SESSION 2 (July 1-3) _proate	_____	_____	_____	_____
SESSION 3 (Jul y 8-12)	_____	_____	_____	_____
SESSION 4 (July 15-19)	_____	_____	_____	_____
SESSION 5 (July 22-26)	_____	_____	_____	_____
SESSION 6 (July 29-Aug 2)	_____	_____	_____	_____
SESSION 7 (Aug 5-9)	_____	_____	_____	_____
SESSION 8 (Aug 12-16)	_____	_____	_____	_____
SESSION 9 (Aug 19-23)	_____	_____	_____	_____