

DEFENDER DAY CAMP ENROLLMENT FORM

Current KR-5th grade student (2018-2019) ***Or enrolled in K-5 2019-2020

Program Dates: May 29 - August 9, 2019

Early Dismissal June 14th (3:00pm) Closed: July 4th & 5th

1st Child _____ Current Grade _____ Gender _____ Birth date _____

2nd Child _____ Current Grade _____ Gender _____ Birth date _____

3rd Child _____ Current Grade _____ Gender _____ Birth date _____

4th Child _____ Current Grade _____ Gender _____ Birth date _____

Home address _____ Home phone _____

Mother's name _____ Father's name _____

Work place _____ Work place _____

Work phone _____ Work phone _____

Cell phone _____ Cell phone _____

Email address _____

****Please circle which number to contact first – if needed****

I WILL SEND MY CHILD: _____ Full day, every day _____ Full day, part of week

(Mark one choice)

_____ Half day, every day (AM or PM) _____ Half day, part of week (AM or PM)

_____ The schedule will vary each week

My child(ren) _____ will or _____ will not be attending the week of July 16-19 for VBS (9:30-11:30am)

ADDITIONAL INFORMATION (Allergies, behavioral/emotional problems, medications)

NAME OF THOSE AUTHORIZED TO PICK UP CHILD OTHER THAN PARENTS:

(Child will be released ONLY to those listed)

1. _____ Driver license # _____ Phone _____

2. _____ Driver license # _____ Phone _____

ACTIVITIES FEE DUE WITH REGISTRATION: \$60.00 first child \$45.00 per additional child

Please see reverse side: PART I OR PART II MUST BE COMPLETED

OFFICE USE ONLY:

AMOUNT PAID _____ CHECK # _____ DATE _____ AUTHORIZED _____

Part I: TO GRANT CONSENT

Please complete both physicians and dentist portion.

I hereby give consent for the following medical care providers and local hospital to be called:

Physician _____ Phone _____

Address _____

Dentist _____ Phone _____

Address _____

Hospital _____ Phone _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for:

1. The administration of any treatment deem necessary by above-named doctors, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist.
2. The transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentist, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

Signature of Parent/Guardian _____ Date _____

Address _____

PART II: REFUSAL TO CONSENT

I do not give my consent for emergency medical treatment for my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

Signature of Parent/Guardian _____ Date _____

Address _____