DEFENDER DAY CAMP ENROLLMENT FORM
Current KR-5th grade student (2016-2017) ***Or enrolled in K-5 2017-2018
Program Dates: May 30- August 11, 2017
Early Dismissal June 16th (3:00pm) Closed: July 4th

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 17-21 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____