DEFENDER DAY CAMP ENROLLMENT FORM
Current KR-5th grade student (2017-2018) ***Or enrolled in K-5 2018-2019
Program Dates: May 29 - August 10, 2018
Early Dismissal June 15th (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 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 <u>do not</u> 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_____