2009 Registration Form
Aldersgate Summer Camp

Student's Name: ____
(Last) (First) (Middle) (Nickname)

Address: ____
(Street) (City) (State) (Zip)

Birth Date: ______________ Age: ________ Grade: _______

Parent Email Address: ______________________________

****

Father's Name: ____________ Home Phone: __________ Cell # __________

Address: ____
(Street) (City) (State) (Zip)

Father's Employer: ___________________ Work Phone: _____________

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Mother's Name: ____________ Home Phone: __________ Cell # __________

Address: ____
(Street) (City) (State) (Zip)

Mother's Employer: ___________________ Work Phone: _____________

List the names of persons who are permitted to pick up your child from the Summer Camp Programs:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Child's T-shirt size (circle one): Small Medium Large

Does your child have any known allergies such as food, medications, plants or animals? Yes No If yes, please explain. __________
____

Does your child require medication to be administered during summer camp hours? Yes No
****If yes, please complete a Medication Administration Form.**

Does your child have any medical condition that we should be aware of while at summer camp? (I.e. asthma, allergies, etc.) Yes No
If yes, please explain. ____

Is there anything your child cannot eat? Yes No
If yes, please list. ____

Does your child have particular fears or anxieties of which we should be aware? Yes No If yes, please explain. _______________________
____

Emergency Care Information:

Child's Doctor: ___________________________ Phone: __________________
Office Address: ____
Child's Dentist: __________________________ Phone: ___________________
Office Address: ____
Hospital Preference: _________________________

If neither parent can be reached, whom should we contact in case of an emergency situation?

____
(Name) (Relationship) (Phone Number)

____
(Name) (Relationship) (Phone Number)

Parent Statement:
I agree that the Director may authorize the physician of her choice to provide emergency care in the event that neither I, nor the family physician can be contacted immediately. I have also, received and read the Parent Handbook and I understand the information outlined in the handbook.

__________________________ _____________
(Parent Signature) (Date)