

# Pope John Paul II Community Summer Camp

Child's Name \_\_\_\_\_ Age as of 6/01/09 \_\_\_\_\_ Grade as of 6/01/09 \_\_\_\_\_ Gender M F  
Address \_\_\_\_\_ City \_\_\_\_\_ State/Zip: \_\_\_\_\_

Home Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Preferred Method of Contact: \_\_\_ Work phone \_\_\_ Home Phone \_\_\_ Cell Phone \_\_\_ E-mail

Child Lives With: \_\_\_\_\_

**Adults Authorized to Pick Up Child (other than parents/guardians) Name** \_\_\_\_\_

Relationship to child \_\_\_\_\_ Phone \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_ Phone \_\_\_\_\_

Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_ Phone \_\_\_\_\_

Phone \_\_\_\_\_

**Is there anyone your child may NOT be picked by** \_\_\_\_\_

## Emergency Contacts)

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_ Phone \_\_\_\_\_

## Camper's Medical Information

Physician Name \_\_\_\_\_ Phone \_\_\_\_\_

Name of Health Insurance Coverage for Child \_\_\_\_\_ Policy # \_\_\_\_\_

## Camper's Special Conditions -

\_\_\_ Allergies (including medication reaction) \_\_\_\_\_

\_\_\_ Asthma \_\_\_ Inhaler used \_\_\_ Bone/Joint Problems \_\_\_\_\_

\_\_\_ Diabetes \_\_\_ Fainting \_\_\_ Heart Problems \_\_\_ Hearing \_\_\_ Sinus Problems \_\_\_ Skin Problems \_\_\_\_\_

\_\_\_ Medications Taken at home \_\_\_\_\_

\_\_\_ Other \_\_\_\_\_

## Parent Permissions - Please initial the following

\_\_\_ I agree to pay outstanding camp balances 7 days before the start of each of my child's camp weeks.

Late payments incur a \$25 fee.

\_\_\_ I understand that changes to my child's registration must be submitted to the PJPII CSC in writing 7 days before the start of each of my child's camp weeks.

\_\_\_ I understand that to receive the sibling discount, siblings must register at the same time for the same camp session.

\_\_\_ I give permission for the PJPII CSC to administer medication to my child supplied by parent (if applicable). Must be in original container with written instructions. Type and dosage \_\_\_\_\_

\_\_\_ I give permission for the PJPII CSC to administer minor first aid treatment to my child.

\_\_\_ I give permission for the PJPII CSC to seek medical treatment for my child in the event of an emergency.

\_\_\_ I give permission for the PJPII CSC to apply sunscreen (supplied by parent) to my child.

*I hereby authorize the staff of Pope John Paul II Regional Catholic Elementary School to act in my behalf to their best judgment in any emergency requiring medical attention, and I hereby waive and release Pope John Paul II Regional Catholic Elementary School from any and all liability for any injuries and illnesses incurred while participating in any way in Pope John Paul II Regional Catholic Elementary School's programs, related events and activities, and in the administration of the substances listed below. I also understand that Pope John Paul II Regional Catholic Elementary School retains the right to use and photographs, videotapes, or any other record of this event for publicity, advertising, or any other legitimate purpose.*

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_