

Director's Use Only:

Weekly Rate: _____

Date: _____ Receipt # _____ Reg. Fee _____ No. _____ Summer School Rate: _____

**NORWALK CHRISTIAN ACADEMY SUMMER DAY CAMP
REGISTRATION FORM**

NAME: _____ GRADE: _____
(Note: One applicant per registration form.) Entering fall 2010

ADDRESS: _____
Street City Zip

PHONE: _____ BIRTHDATE: _____ AGE: _____
Mo. Day Yr.

FATHER'S NAME: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

MOTHER'S NAME: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Heard about Day Camp from: Church School _____ Work Friend

Other _____ Siblings in the program: _____

PLEASE CIRCLE THE WEEKS YOU ARE REGISTERING FOR:

6/14 6/21 6/28 7/5 7/12 7/19 7/26 8/2 8/9 8/16 8/23 8/30

FULL PAYMENT for each week is due on Monday the week of attendance. **Payments are made directly to Norwalk Christian Academy.**

I understand that my child (ren) will not be able to attend Tuesday's trip if the current week's day camp fees have not been paid in full.

I have also read the Norwalk Christian Academy Summer Day Camp Guidelines (2 pages) and agree to adhere to all policies.

SIGNED: _____ DATE: _____
Parent(s) or Guardian(s)

DAY CAMP T-SHIRTS ARE REQUIRED FOR ALL OUTINGS OR THEY MAY NOT ATTEND. THE FIRST T-SHIRT IS FREE. PLEASE INDICATE CHILD T-SHIRT SIZE. We recommend at least 2 t-shirts. When ordering, please remember that the sizes run small. WE WILL ONLY PUT IN ONE T-SHIRT ORDER.

CHILD: Small (6-8) Medium (10-12) Large (14-16)

ADULT: Small Medium Large XL XXL

TOTAL NUMBER OF T-SHIRTS DESIRED (including the first FREE T-shirt): _____

PLEASE FILL OUT MEDICAL RELEASE FORM ON BACK SIDE

MEDICAL RELEASE FORM

I, (We), the undersign, parent(s) of _____ a minor, do hereby authorize the Norwalk Christian Academy, its adult agents and employees, in whose care said minor has been entrusted while attending the Norwalk Christian Academy Summer Day Camp, to consent to any X-Ray examination, anesthetic, medial or surgical diagnosis, or treatment and hospital care which is deemed advisable by and is to be rendered at the office of said physician or at said hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to employees, to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his best judgment any deem advisable. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

This authorization shall remain effective until 7:00 p.m., September 3, 2010 unless sooner revoked in writing delivered to said agent(s).

The undersigned is (are) a person(s) having legal custody of, or is (are) the legal guardian(s) of said minor.

SIGNED: _____ DATE: _____

NAME OF HEALTH INSURANCE: _____ POLICY #: _____

FAMILY PHYICIAN: _____ PHONE #: _____

PERMISSION TO ADMINISTERED TYLENOL: Yes No

DATE OF LAST TETANUS SHOT: _____

FOOD ALLERGIES: _____

EMERGENCY CONTACT OTHER THAN PARENTS:

NAME: _____

RELATIONSHIP: _____ PHONE #: _____

NAMES OF PEOPLE TO WHOM CHILDREN MAY BE RELEASED:

- | | | |
|----------|--------------|----------------|
| 1. _____ | Relationship | PHONE #: _____ |
| 2. _____ | Relationship | PHONE #: _____ |
| 3. _____ | Relationship | PHONE #: _____ |
| 4. _____ | Relationship | PHONE #: _____ |
| 5. _____ | Relationship | PHONE #: _____ |