

Allentown Central Catholic High School

MIDDLE SCHOOL SUMMER

Enrichment Camp Registration Form

Camper Information

Camper Name _____ DOB _____ Gender Female Male

Address _____ City _____ State _____ Zip _____

Elementary School _____ Grade for 2022-2023 5 6 7 8 9

Parent/Guardian Information

Parent/Guardian #1 Name _____ Cell Phone _____

E-mail _____

Parent/Guardian #2 Name _____ Cell Phone _____

E-mail _____

Adults Authorized to Pick-up Student

Name	Relationship to Student	Cell Phone	Em. Contact?
			<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Y <input type="checkbox"/> N

Please explain any custody arrangement.	Please list any allergies.

Camp Tuition is \$200/week or \$550 for all 3 weeks. *Full scholarships are available to anyone in need.* Payment due July 1, 2022. Please select the weeks camper is available to attend by placing an X under the selection column.

<input type="checkbox"/> Will pay in full by July 1, 2022		<input type="checkbox"/> Requesting scholarship funding		
Session	Theme	Week	Schedule	Selection
1	Under the Sea	July 11-15	M-F 9:00-1:00pm	<input type="checkbox"/>
2	Space Week	July 18-22	M-F 9:00-1:00pm	<input type="checkbox"/>
3	Fantasy Week	July 25-29	M-F 9:00-1:00pm	<input type="checkbox"/>

ALLENTOWN CENTRAL CATHOLIC MIDDLE SCHOOL SUMMER ENRICHMENT CAMP

MEDICAL/PHYSICAL INFORMATION

Camper Name _____ DOB _____ Gender Female Male
Elementary School _____ Grade for 2022-2023 _____ Emrg. Tel # _____

Doctor's Name _____ Tel. # _____
Hospital Preference _____ Second Choice _____
Insurance Company _____ Policy No. _____ Group No. _____
Dentist's Name _____ Tel. # _____

In a medical emergency, we hereby authorize the school to seek emergency medical assistance for our child if we cannot be reached.

Parent/Guardian Signature _____ Parent/Guardian Signature _____ Date _____

Please keep a copy of this form for your records. IMPORTANT: Please update your school immediately if any information changes.

Does your child have a history of any of the following conditions? If so, please explain type of medical treatment.

Table with 2 columns: YES, NO. Rows include: ADD/ADHD, Asthma, Diabetes, Food or Drug Allergy, Bee Sting Allergy, Seizure Disorder, Condition Limiting Physical Education, Migraine Headaches, Other Chronic or Recurrent Conditions, Glasses/Contacts (Please Circle) (When to be Worn), Presently Taking Medications.

Names of Medication

Reasons for Taking Medication

STUDENT HEALTH INFORMATION

In the event that my child should become seriously ill or injured while in the school and require prompt emergency care, I give my permission to the attending physician for any necessary emergency medical treatment.

Parent/Guardian Signature _____ Parent/Guardian Signature _____ Date _____

Please Print Name of Parent/Guardian Signature _____ Please Print Name of Parent/Guardian Signature _____ Date _____