KRIS' CAMP / THERAPY INTENSIVE PROGRAMS, INC. 2017/18 THERAPY CAMPS REGISTRATION APPLICATION RETURNING CAMPERS FORM Page 1 of 5

QUICK REFERENCE

CAMPER NAME:
CAMP SESSION & DATES:
AGE AT CAMP:
MEDICATIONS (DOSES AND FREQUENCY):
DIETARY RESTRICTIONS/REQUIREMENTS:
ALLERGIES (INCLUDING FOOD ALLERGIES):
PARENT/GUARDIAN CONTACT INFO AT CAMP (PLEASE PROVIDE TELEPHONE NUMBER/S, AND CABIN/LODGING IF KNOWN):

3 GOALS FOR YOUR CHILD FOR CAMP:

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CAMPER NAME:						
CAMP SESSION & DATES:						
PARTICIPANT INFORMATION						
PLEASE LIST ALL PEOPLE ATTENDING CAMP. WE WILL BE USING THIS INFORMATION IN PART TO DETERMINE THE AMOUNT OF FOOD TO PURCHASE AND PREPARE, AS WELL AS STAFFING NEEDS.						
PLEASE PUT AN '*' NEXT TO ALL SIBLINGS WHO WILL BE ATTENDING SIBLING CAMP. (please note if someone will be attending only a portion of the camp session):						
NAME	RELATIONSHIP	BIRTHDATE	FOOD ALLERGIES			
1.						
2.						
3.						
4.						
5.						
6.						
BILLING INFORMATION NAME AND ADDRESS OF WHO WE WILL BE BILLING FOR KRIS' CAMP – 50% tuition is due 60 days prior to your camp session; the balance is due 30 days prior:						
PERSON NOT ATTENDING CAMP TO CONTACT IN CASE OF EMERGENCY: NAME: ADDRESS:						
RELATIONSHIP:	HOME PHON	JE:				
WORK PHONE:	OTHER PHONE:					

ANY OTHER INFORMATION YOU WISH TO SHARE:

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Please mail this entire completed application and the 2 completed release forms (below), and a copy of your child/ren's immunization records and/or a doctor's note to**:

Kris' Camp 757 West Pine Ave St George Island, FL 32328

**If you submitted your child's immunization records in a previous year/session, you do not need to resubmit them as we keep them on file.

Check one:
I have already submitted the Initial Registration Form and \$250 deposit I am including my Initial Registration Form and \$250 deposit with this application
I have included a copy of camper and sibling immunization records and/or a doctor's note.
Kris' Camp already has a copy of our immunization records from a previous year.
Thank You! We look forward to seeing you at camp!
IF YOU HAVE ANY QUESTIONS OR CONCERNS ABOUT THIS APPLICATION PLEASE CONTACT KATHY BERGER at 850-445-4821 OR kberger62@gmail.com

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<u>RELEASE FORM</u>
Please list all children who will be attending therapy or sibling camp

I,	(MOTHER/FATHER/LEGAL GUARDIAN) OF
(LIST ALL ATTEN	DING CHILD/REN)
INCLUDING ACCI INVOLVEMENT W	EASE KRIS' CAMP AND IT'S STAFF OF ALL LEGAL RESPONSIBILITIES DENTAL INJURY, DISMEMBERMENT, OR DEATH RESULTING FROM MY CHILD'S //ITH KRIS' CAMP. THIS INCLUDES TRANSPORTATION TO AND FROM PLACE OF RIS' CAMP, ALL ACTIVITIES WHILE ATTENDING KRIS' CAMP, AND RETURN TO ENCE.
Initials	Date
FOR THE PURPOS INCLUDING THE	ON FOR MY CHILD TO BE PHOTOGRAPHED, AND FOR PICTURES TO BE UTILIZED ES OF KRIS' CAMP INFORMATIONAL AND FUNDRAISING PUBLICITY NEWSLETTER, DVD YEARBOOK FOR DONORS, LOCAL NEWSPAPER, KRIS' CAMP NUING EDUCATION BROCHURE, AND GENERAL CAMP BROCHURE.
Initials	Date
Parent/Guardian Sig	natura
Parent/Guardian Sig	nature
Relationship to Child	d/ren
Date	
Witness Signature	
Print Name Here	
Date	

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Medical Release Form

I hereby give permission for any and all medical attention necessary to be administered to my child/ren (name/s):

in the event of accident, injury, sickness, etc., under the direction of either of the person(s) designated below, until such time as I may be contacted. If neither of the person(s) designated below can be contacted, I give permission for treatment of my child as may be required subsequent to a determination made by the appropriate health care professional who is present. This release is effective until revoked, in writing, by me. I also hereby assume responsibility for payment of such treatment.

My name:						
Phone (H):	(W):	(M):				
Phone/cabin/contact info while at camp (Therapy campers only):						
My Street Address:						
City:	State:	Zip:				
My insurance company is:						
My insurance policy number is:						
In case I cannot be reached, either of the following is designated:						
Emergency Contact 1:		Phone:				
Emergency Contact 2:		Phone:				
My child/rens' physician:		Phone:				
Physician's address:						
Known allergies of child:						
Current medications for child:						
Health conditions (i.e. seizures, asthma, etc.):						
Parent/Guardian Signature						
Print Name						

Date