

KRIS' CAMP / THERAPY INTENSIVE PROGRAMS, INC.
2017/18 THERAPY CAMPS REGISTRATION APPLICATION
RETURNING CAMPERS FORM
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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 PHONE:

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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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