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:

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:

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

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
1132 Green Hill Trace
Tallahassee, FL 32317

****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:

☐ ***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.

RELEASE FORM

****Please list all children who will be attending therapy or sibling camp****

I, _____(MOTHER/FATHER/LEGAL GUARDIAN) OF
_____
(LIST ALL ATTENDING CHILD/REN)

HEREBY DO RELEASE KRIS' CAMP AND IT'S STAFF OF ALL LEGAL RESPONSIBILITIES INCLUDING ACCIDENTAL INJURY, DISMEMBERMENT, OR DEATH RESULTING FROM MY CHILD'S INVOLVEMENT WITH KRIS' CAMP. THIS INCLUDES TRANSPORTATION TO AND FROM PLACE OF RESIDENCE TO KRIS' CAMP, ALL ACTIVITIES WHILE ATTENDING KRIS' CAMP, AND RETURN TO PLACE OF RESIDENCE.

_____ _____
Initials Date

I GIVE PERMISSION FOR MY CHILD TO BE PHOTOGRAPHED, AND FOR PICTURES TO BE UTILIZED FOR THE PURPOSES OF KRIS' CAMP INFORMATIONAL AND FUNDRAISING PUBLICITY INCLUDING THE NEWSLETTER, DVD YEARBOOK FOR DONORS, LOCAL NEWSPAPER, KRIS' CAMP WEBSITE, CONTINUING EDUCATION BROCHURE, AND GENERAL CAMP BROCHURE.

_____ _____
Initials Date

_____
Parent/Guardian Signature

_____
Relationship to Child/ren

_____
Date

_____
Witness Signature

_____
Print Name Here

_____
Date

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