Office Use Only: Date of Admission _______________

DISCOVERY Summer Camps 2010

301 Hays Country Acres Rd. ~ Dripping Springs TX 78620 ~ 512.858.4924
web: www.discoverydayschool.org email: mmilligan@discoverydayschool.org

Registration

Child's Name: ______________________ **Date of Birth:** ______________

Address City Zip: ______________________________________

Home Phone: ______________________ **Cell Phone:** ______________

Email: ______________________________________

Sign me up! ☐	*Sign me up!* ☐	*Sign me up!* ☐	*Sign me up!* ☐
Explore Nature	*Fairy Tales*	*Beach Fun*	*Space Adventure*
June 7-June 11	June 21-June 25	July 5-July 9	July 19-July 23
9am-1pm	9am-1pm	9am-1pm	9am-1pm
Camp Fee $60	Camp Fee $60	Camp Fee $60	Camp Fee $60
Ages 2-7 years	Ages 2-7 years	Ages 2-7 years	Ages 2-7 years

Snack: One snack per day will be supplied by the Discovery Day School program.
Camp Fee: Due at time of registration. All checks should be made payable to ECHS Discovery Day School. A $25 fee will be charged for all returned checks.

Parents or Guardians

Name 1 ______________________ TXDL #: ______________

Work Phone: ______________________ Cell Phone: ______________

Employer: ______________________ Occupation: ______________

Name 2 ______________________ TXDL #: ______________

Work Phone: ______________________ Cell Phone: ______________

Employer: ______________________ Occupation: ______________

Parents Are (circle): Married Divorced Separated Single

Should the child be under the legal custody of only one parent, a copy of the final court judgment must be on file at The Episcopal Church of the Holy Spirit.

Parent Signature: ______________________ Date: ______________

Parent's Name (Print): ______________________

Emergency Information & Release

Child's Name: ______________________ **Date of Birth:** __________

Insurance Co: ______________________ **Policy #:** __________

Physicians Name: ______________________ **Phone:** __________

Address: ______________________

Hospital/Clinic: ______________________ **Phone:** __________

Address: ______________________

Emergency Contact Phone Numbers

Work Numbers:

Mother/Guardian: ______________ Father/Guardian: ______________

Mobile Numbers:

Mother/Guardian: ______________ Father/Guardian: ______________

Alternate Persons for Emergency Contact and School Pickup:

Name: ______________________ Relationship: __________

Address: ______________________ Phone: __________

Name: ______________________ Relationship: __________

Address: ______________________ Phone: __________

Parental Permission:

1. I give my permission for my child to participate in all regularly planned activities and field trips.
2. I give my permission to have my child in any media coverage approved by The Episcopal Church of the Holy Spirit.
3. I hereby release The Episcopal Church of the Holy Spirit, its officers and representatives of all liabilities arising out of enrollment in this program.

In the event that I cannot be reached to arrange for emergency medical attention at the time of an illness or accident, I hereby give consent to the program director, or representatives of The Episcopal Church of the Holy Spirit and/or Program to take my child to the above named hospital/clinic or the closest hospital/clinic for any and all necessary treatment. I also assume all financial responsibility.

CAUTION: No medications will be stored at school or administered by staff. The Episcopal Church of the Holy Spirit and its representatives will not administer medications at any time.

Parent Signature: ______________________ Date: __________

Parent's Name (Print): ______________________

My Camp Leader and Me

Child's Name: ______________________

Parents Names: ______________________

Email Contact: ______________ Phone: ______________

Mailing Address: ______________________

Allergies & reactions to them:

____

____

Special health conditions & descriptions:

____

____

Blood Type: ______________________

Toileting: ☐ Not potty trained ☐ Starting potty training ☐ Ready to go!

How can we help? ______________________

Child's Favorites:

Foods ______________________

Toys ______________________

Activities ______________________

Child's Behavior:

Any special fears? ______________________

What comforts your child? ______________________

What stops misbehavior? ______________________

What is used for distraction? ______________________

Sibling Name: ______________ Age: ______________

Sibling Name: ______________ Age: ______________

Sibling Name: ______________ Age: ______________

Medical Information

All children must be up-to-date on their immunizations to be eligible to attend school. In order to comply with state requirements, a current copy of your child's immunization record signed by the physician or a health professional must be on file at The Episcopal Church of the Holy Spirit. It is required by the State of Texas that each child must have been seen by a physician within the last 12 months to assess the health of the child.

Name of Child: ______________________ **DOB:** ____________

Immunizations	Date/Dose 1	Date/Dose 2	Date/Dose 3	Date/Booster	Date/Booster
DTP / DTaP / DT					
POLIO IPV					
MEASLES					
MUMPS					
RUBELLA					
HIB					
HEPATITIS A					
HEPATITIS B					
TB TEST (if required)	Positive ☐	Negative ☐	Date:		
VARICELLA (see below)					

____

Signature - Physician or Health Personnel Date & Signature - Staff Making Handwritten Copy of Record Date

Varicella (chicken pox) vaccine is not required if your child has had chicken pox disease. If your child has had chicken pox, please complete the statement: My child had varicella disease (chicken pox) on or about (date) ____________ and does not need varicella vaccine.

____

Parent Signature Date

Check one option only:

☐ If medical diagnosis and treatment and/or immunization and TB testing conflict with your religious beliefs, you must sign an affidavit to that effect and attach it to this form. If immunization and/or TB testing would be injurious to your child or family, you must obtain a certificate (signed by a physician) to that effect and attach it to this form.

☐ Healthcare Professional Statement: This child was examined by me on ________________ (date) and found to be free of all contagious diseases and is physically able, with the exceptions noted, to participate in the Discovery Day School Program at The Episcopal Church of the Holy Spirit.

☐ A signed and dated copy of a health care professional's statement is attached.

☐ My child has been examined within the past year by a health care professional and is able to participate in the program. Within 12 months of admission, I will obtain a health care professional's signed statement and will submit it to the child-care operation.

Physician's Signature: ______________________ Date: ____________
Print Name: ______________________
Address/City/Zip: ______________________ Phone: ____________

____

Parent Signature Date