

Office Use Only: Date of Admission _____



Summer Camps

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

2011

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!

Growing Up Wild	He's Got the Whole World in His Hands	Eric Carle Adventures	Famous Inventors
June 20-June 24	June 27-July 1	July 11-July 15	July 25-July 29
9am-Noon	9am-Noon	9am-Noon	9am-Noon
Camp Fee \$65	Camp Fee \$65	Camp Fee \$65	Camp Fee \$65
Potty Trained 3 to 7 years	Potty Trained 3 to 7 years	Potty Trained 3 to 7 years	Potty Trained 3 to 7 years
Snack Provided	Snack Provided	Snack Provided	Snack Provided

Camp fee due at time of registration. Please make checks payable to ECHS DDS.

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

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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 Camp Pickup

Name: _____ Address: _____
 Relationship: _____ Phone: _____
 Name: _____ Address: _____
 Relationship: _____ Phone: _____

Parental Permission

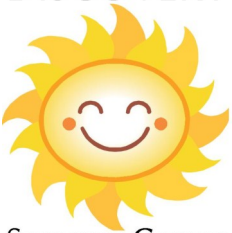
1. I give my permission for my child to participate in all regularly planned activities and field trips.
2. I give my permission to have my child in any media coverage approved by The Episcopal Church of the Holy Spirit.
3. I hereby release The Episcopal Church of the Holy Spirit, its officers and representatives 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 staff or representatives will not administer medications at any time, as stated in the program Parent Handbook.

Parent Signature: _____ Date: _____

Parent's Name (Print): _____



Summer Camps

My Camp Leader and Me

Summer Camp 2011

Child's Name:

Parents Names:

Email Contact:

Phone:

Mailing Address:

Allergies & reactions to them:

Special health conditions & descriptions:

Blood Type:

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:



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Medical Information Summer Camp 2011

All children must be up-to-date on their immunizations to be eligible to attend camp. 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.

Child's Name: _____

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					
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 _____

FOR 4 YEAR OLDS ONLY: _____ Physicians Signature ↓ Date _____

Vision R: 20/ _____ L: 20/ _____ Pass / Fail _____ Date _____

Hearing 1000 Hz 2000 Hz 4000 Hz Pass / Fail **Physicians Signature ↓ Date**

Right						
Left						

CHECK ONE OPTION ONLY:

- If medical diagnosis and treatment and/or immunization 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: _____ Phone: _____

Address/City/Zip: _____