

Imagination Day Camp

CAMP PROGRAM for 5 - 8 YEAR OLD GIRLS

P.O. Box 102
Stony Brook, NY 11790
246-5269

e-mail: Eileen@ImaginationPreschool.com

CAMP REGISTRATION FORM - 2010

Child's Name _____ Date of birth _____ Age _____

Address _____

Town _____ Zip code _____

Home phone _____ Business phone _____

Cell phone _____ E-mail _____

Father's name _____ Mother's name _____

Please indicate your child's t-shirt size:

Small (6 – 8)

Medium (10 – 12)

Large (14 – 16)

Please check the boxes below for your summer session choice of days and weeks
(minimum of 2 days per week):

***** Registration for 3 days a week must include a Monday or Friday. *****

	Monday	Tuesday	Wednesday	Thursday	Friday
Week 1 7/12 – 7/16					
Week 2 7/19 – 7/23					
Week 3 7/26 – 7/30					
Week 4 8/2 – 8/6					
Week 5 8/9 – 8/13					

Summer session hours for Girls Camp: 9:30 AM to 12:30 PM.

HEALTH INFORMATION

Child's name _____

Physician's name _____

Physician's phone _____

Has your child had any of the following:

	No	Yes	If yes, date of occurrence
Serious Accidents			
Serious Illness			
Operations			
Hospitalizations			
Handicaps			
Allergies			

If you answered yes to any of the above, or if there is any other information we should know about your child, please explain below:

Are there any foods that your child cannot eat (allergies, etc.)?

In case of an unscheduled pickup of your child due to illness, please list the names and telephone numbers of four friends or relatives who we should try to contact if the parents cannot be reached:

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Authorization:

In case of an emergency where parents or designated contacts cannot be reached, I hereby give permission to the staff at Imagination Pre-School to take my child to the emergency room at Stony Brook Hospital. I also give permission for the hospital staff to treat my child as required.

Parent's signature _____ Date _____

The camp director is trained and certified in First Aid by the American Red Cross. We will administer first aid for minor cuts or bruises and we will inform you when you pick up your child. If further treatment seems necessary, we will notify you or your designated emergency contact.

PLEASE KEEP YOUR CHILD HOME UNDER THE FOLLOWING CONDITIONS; if vomiting or diarrhea lasts over several hours, if your child seems listless, unusually irritable, complains of headache, stomach ache, sore throat or ear ache, or seems unusually pale or flushed. A child with a temperature of 101.5° or above is expected to stay home for a 24-hour period. It is better to be overcautious than to risk the health of your child or the chance of exposing other children to illness. Children returning to camp after recovering from a communicable disease will need a doctor's note stating that they are no longer contagious.

RELEASE AUTHORIZATION

Child's name _____

Imagination Day Camp will not release your child to anyone other than those for whom we have written permission. Please use the space below to write the names of relatives, friends, or neighbors who may at some time be taking your child home from camp.

Please notify our staff if a designated person other than a parent or guardian is picking up your child. Any person picking up your child must be listed on this form and should be prepared to show photo identification.

Please tell us about your child's personality and anything in particular that we should know about your child.
