

CHILD'S NAME: _____

FIRST

MI

LAST

MAILING ADDRESS: _____

STREET OR P.O. BOX

TOWN/CITY

STATE ZIP

CHECK ONE: FEMALE MALE DOB: _____ AGE: _____ LAST GRADE COMPLETED: _____

BEST PHONE NUMBER WHERE CAMPER CAN BE REACHED: _____ (USED ONLY BY COUNSELOR TO WELCOME CAMPER)

BEST EMAIL _____ OR _____

WEEK	EARLY BIRD RATE CAMPER GRK-6 BEFORE JUNE 1ST	CAMPER GR K-6 AFTER JUNE 1ST	L.I.T. GRADE 7-9	DEPOSIT ENCLOSED	EARLY BIRD BAL DUE, POSTMARKED BY JUNE 15 TH	AMT DUE	COMPLETED REGISTRATION FORM, IMMUNIZATION RECORDS <u>AND</u> FULL PAYMENT POSTMARKED BY THURSDAY,
<input type="checkbox"/> #1 JUNE 28-JULY 2	\$233	\$258	\$145.				JUNE 17
<input type="checkbox"/> #2 JULY 5-9	\$233	\$258	\$145.				JUNE 24
<input type="checkbox"/> #3 JULY 12-16	\$233	\$258	\$145.				JULY 1
<input type="checkbox"/> #4 JULY 19-23	\$233	\$258	\$145.				JULY 8
<input type="checkbox"/> #5 JULY 26-30	\$233	\$258	\$145.				JULY 15
			TOTAL				

NOTE: FLEXIBLE PAYMENT PLAN AVAILABLE FOR MULTIPLE WEEK AND/OR MULTIPLE CAMPER FAMILIES

FOR MORE INFORMATION, PLEASE CONTACT US AT INFO@ARTHARBOR.ORG

CONTACT INFORMATION

MOTHER
 FATHER NAME:
 OTHER
 CELL:
 DAY:
 EVEN:

MOTHER
 FATHER NAME:
 OTHER
 CELL:
 DAY:
 EVEN:

EMERGENCY CONTACT

**SAME CONTACT
 INFO AS ABOVE**

MOTHER
 FATHER NAME:
 OTHER
 CELL:
 DAY:
 EVEN:

RELEASE INFORMATION

MY CHILD IS ATTENDING ART HARBOR CAMP AT WINDHOVER AND MAY BE RELEASED TO THE FOLLOWING ADULTS. I UNDERSTAND THAT WITHOUT MY WRITTEN CONSENT HE/SHE WILL NOT BE RELEASED TO ANY OTHER THAN THOSE NAMED BELOW.

RELEASE #1

MOTHER
 FATHER NAME:
 OTHER
 CELL:
 DAY:
 EVEN:

RELEASE #2

MOTHER
 FATHER NAME:
 OTHER
 CELL:
 DAY:
 EVEN:

RELEASE #3

MOTHER
 FATHER NAME:
 OTHER
 CELL:
 DAY:
 EVEN:

My L.I.T. _____ MAY LEAVE CAMP AT THE END OF THE CAMP DAY WITHOUT AN ADULT. YES NO

L.I.T NAME

CAMPER/LIT PHOTOGRAPH/VIDEO RELEASE 2010

INITIAL HERE _____ YES NO I GIVE ART HARBOR CAMP AT WINDHOVER PERMISSION TO TAKE, USE AND PUBLISH PHOTOGRAPHS AND/OR VIDEO OF MY CHILD FOR USE IN ART HARBOR PUBLICITY OR PUBLICATIONS.

MEDICAL INFORMATION

1. HEALTH INSURANCE MEMBER ID #: _____ INS COMPANY: _____
2. PHYSICIAN'S NAME: _____ PHONE: _____
3. PHYSICIAN'S HOSPITAL AFFILIATION: _____ PHONE: _____
4. **INITIAL HERE** _____ YES NO CAMP DIRECTOR CONTACT ME REGARDING MY CHILD'S MAJOR HEALTH ISSUES THAT NEED SPECIAL MONITORING
5. ALLERGIES-CHECK ALL THAT APPLY:
 NONE FOOD POISON IVY/OAK HAY FEVER MOSQUITOES INSECT STINGS OTHER: _____
6. ACTIVE HEALTH CONCERNS CHECK ALL THAT APPLY: **NONE** SEIZURES DIABETES ASTHMA FAINTING
SOCIAL/EMOTIONAL CARDIAC CONDITIONS OTHER: _____
7. ACTIVITIES TO BE RESTRICTED: NONE YES IF YES, PLEASE LIST HERE: _____
8. DATE LAST SEEN BY A PHYSICIAN: _____
9. CURRENT HEALTH ASSESSMENT **AND** IMMUNIZATION RECORDS ATTACHED
10. **INITIAL HERE** _____ MEDICAL AUTHORIZATION: ALL MEDICATION MUST BE GIVEN TO THE HEALTH SUPERVISOR(S) IN ITS ORIGINAL, LABELED CONTAINER, CLEARLY MARKED WITH THE CAMPER'S NAME, DATE, DOSAGE AND TIMES TO BE GIVEN. MEDICATIONS WILL BE GIVEN ONLY BY THE HEALTH SUPERVISOR(S). PLEASE LIST ALL CURRENT MEDICATIONS, DOSAGE INSTRUCTIONS BELOW:
MEDICATION: _____ DOSAGE: _____

MEDICATION: _____ DOSAGE: _____

MEDICATION: _____ DOSAGE: _____
11. **INITIAL HERE** _____ YES NO PERMISSION FOR HEALTH SUPERVISOR(S) TO GIVE TYLENOL/BENADRYL AS DIRECTED ON PACKAGE IF DEEMED NECESSARY BY THE HEALTH SUPERVISOR(S)
12. **INITIAL HERE** _____ YES NO PERMISSION FOR HEALTH SUPERVISOR(S) TO APPLY CALADRYL TOPICALLY, AS DIRECTED ON PACKAGE IF DEEMED NECESSARY BY THE HEALTH SUPERVISOR(S)
13. **INITIAL HERE** _____ **AUTHORIZATION FOR EMERGENCY MEDICAL CARE**
IN CASE OF EMERGENCY, MEDICAL ATTENTION WILL BE PROVIDED BY THE HEALTH SUPERVISOR(S) ON SITE. THE CAMP WILL ATTEMPT TO CONTACT PARENT/GUARDIAN AND CALL THE CHILD'S PHYSICIAN. IN THE EVENT THAT THE CAMP IS UNABLE TO CONTACT THE PARENT/GUARDIAN, YOUR CHILD WILL BE TRANSPORTED BY AMBULANCE TO ADDISON GILBERT HOSPITAL EMERGENCY DEPARTMENT ACCOMPANIED BY A STAFF MEMBER.
I HEREBY AUTHORIZE ART HARBOR THROUGH ITS TRAINED STAFF AND/OR THE LOCAL HOSPITAL (ADDISON GILBERT HOSPITAL, GLOUCESTER, MA), ITS PHYSICIANS AND STAFF, TO ACT IN THE BEST INTEREST OF MY SON/DAUGHTER IN THE EVENT OF INJURY OR MEDICAL PROBLEM NEEDING IMMEDIATE MEDICAL ATTENTION.

PARENT/GUARDIAN SIGNATURE _____ **DATE** _____

ADDITIONAL SPACE FOR MEDICAL NOTES:

CHECKLIST OF ITEMS TO INCLUDE IN YOUR ENVELOPE:

- THIS COMPLETED FORM
- CAMP TUITION DEPOSIT/FULL PAYMENT
- CURRENT IMMUNIZATION RECORDS FROM YOUR CHILD'S DOCTOR'S OFFICE

PLEASE MAIL TO:

ART HARBOR PO BOX 818 ROCKPORT MA 01966