

St. Stephen 2009 Summer Day Camp Child Profile

2100 Baseline Road

Grand Island, NY 14072

Phone 773-7647 Fax 773-5792 During Camp 909-5153

CHILD PROFILE/REGISTRATION FORM

Date Completed: _____

Child's Name: _____

Age: _____ Grade (Sep. 2009) _____ School: _____

Address: _____

City, State, Zip: _____

Parent Name(s):

Mother: _____ Work Phone: _____

Father: _____ Work Phone: _____

Emergency Contact/Phone: _____

Person(s) responsible for picking up child: _____

Note: Your child will only be released
to individuals indicated on this form _____

Illness, disability, or allergy information: _____

Specify special diet restrictions: _____

1. Medication that must be given to my child on a daily basis will be given to the director the first day of camp with clear directions, Doctor's name, and name of medication.
2. In case of accident or serious illness, I request the Day Camp to contact me. If the Day Camp is unable to reach me, I hereby authorize the Day Camp to call the physician indicated below and to follow his/her instructions. If it is impossible to contact this physician, the Day Camp may make whatever arrangements are necessary.

Signature of Parent or Guardian: _____

Physicians Name: _____ Phone: _____

Address: _____

Remarks: _____

OFFICE USE ONLY: Current Immunization record submitted ____/____/____