ST. CATHERINE OF BOLOGNA SCHOOL
112 Erskine Road, Ringwood, NJ 07456
(973) 962-7131

Summer Camp Registration Form

July 2017

Week 1:	**Week 2:**	**Week 3:**	**$50 non-refundable deposit required at time of registration**
July 10-14_____	July 17-21_____	July 24-28_____	**Check** _____ **Cash** _____

CHILD'S FULL
NAME:_____Male:_____ Female:_____

Address:_____

Telephone Number:_____CELL:_____

Birthdate:_____ Grade:_____

Church Affiliation:_____ Language spoken at home:_____

Father's Name:_____

Father's Address:_____

Work Address:_____Phone:_____

Email:_____ Cell:_____

Mother's Name:_____

Mother's Address:_____

Work Address:_____Phone:_____

Email:_____ Cell:_____

Are you willing to abide by St. Catherine of Bologna Summer Challenge Camp regulations?_____

Parent / Legal Guardian:_____

Signature:_____ Date:_____

I submit the information here as true and accurate to the best of my knowledge.

Signature:_____ Date:_____

ST. CATHERINE OF BOLOGNA SCHOOL

Summer Challenge Camp – July 2017

EMERGENCY CONTACT INFORMATION

Week 1:
July 10-14_____

Week 2:
July 17-21_____

Week 3:
July 24-28_____

Family Name_____**Phone**_____

Address_____

_____

Child's Name and Grade: **1)**_____

2)_____

_____

Mother's Name_____

Work Address_____**Phone**_____

Cell Phone_____**email**_____

Father's Name_____

Work Address_____**Phone**_____

Cell Phone_____**email**_____

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List two neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached.

Name_____**Phone**_____

Address_____**Relationship to Student**_____

Name_____**Phone**_____

Address_____**Relationship to Student**_____

****

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated below and to follow his instructions. If it is impossible to contact this physician, the school may make whatever arrangements seem necessary.

Number each item 1, 2, 3, 4 in order of desired action.

(☐) **Contact family physician**_____**Phone**_____

(☐) **Take child to emergency hospital** _____
I understand my child may have to be transported to the nearest hospital

(☐) **Take child to any licensed physician**_____

(☐) **Other desired procedures**_____

_____

Signature of Parent/Guardian_____**Date**_____

→ Fill out ALL information and return by JUNE 30, 2017 - Please print legibly ←

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ALLERGY - MEDICAL INFORMATION

Dear Parents/Guardians:

In light of the Privacy Act concerning medical information, we require your permission to release any allergy, asthma, or medical data to your child's teachers. Please complete and sign the release form below so we may distribute this information to the appropriate faculty and staff. If we do not receive a release, we cannot release this information to your child's teachers.

Thank you,

Nursing Office

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Name of student:_____**Grade:**_____
(please print)

_____ Not Applicable - [Please return form for records]

MEDICAL RELEASE PERMISSION

Please list allergy information:

_____

_____

_____

_____ I give my permission for my child's allergy/asthma or medical information to be released to pertinent faculty and staff members.

_____ I **do not** give my permission for my child's allergy/asthma or medical information to be released to pertinent faculty and staff members.

Signature
Parent/Guardian:_____ **Date:**_____

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Summer Challenge Camp – 2017

PHOTO PERMISSION

During Summer Challenge Camp, situations arise where your child might be photographed or videotaped.

Do we have your permission to have your child's picture in a local newspaper, shown on our local TV channel, or on our school website?

_____ Yes, you have my permission for website

_____ Yes, you have my permission for newspaper or TV

_____ No, you do not have my permission for website

_____ No, you do not have my permission for newspaper or TV

Child's Name: _____

_____

Parent Signature:_____Date:_____