St. Philip Summer Camp Enrollment

St. Philip Lutheran School ✞ 8850 Davona Drive, Dublin, CA 94568 ✞ 925-829-3857

★**PLEASE FILL OUT FORM COMPLETELY AND RETURN WITH TOTAL TUITION FEE BY JUNE 2ND, 2017**

Student's Full Name_____Grade in 2017 – 18 _____ (K-8 only)

Goes by_____ Gender_____

Address_____City_____Zip_____

Home Telephone_____Date of Birth_____

Father's Full Name_____Mother's_____

Father's Occupation_____Mother's_____

Work Telephone_____Work Telephone_____

Cell Telephone_____Cell Telephone_____

Email Address_____Email Address_____

Names of brothers and/or sisters	Date of Birth	School

☆☆**Additional information Summer Camp should know** (allergies, physical handicaps, special needs, medications, etc.)

_____

Can we post photos of your child on Facebook: YES_____ NO_____

We as parents agree to cooperate with the **St. Philip Summer Camp** program and policy:

_____

Signature of Father Signature of Mother Date

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OFFICE USE ONLY: App. Received - Date_____

Tuition Fee _____Amount $_____Check #_____

St. Philip Lutheran Summer Camp Emergency Care & Consent Form

Physician_____ Address_____

Physician Phone (_____) _____ Medical Record #_____

Choice of Hospital_____ Phone (_____) _____

Other responsible people (friends or relatives) that could be called in an **EMERGENCY**:

1. Name_____ Relationship_____ Address_____

Phone (_____) _____ Phone (_____) _____

2. Name_____ Relationship_____ Address_____

Phone (_____) _____ Phone (_____) _____

CONSENT FOR MEDICAL TREATMENT ****Your child must be fever free for 24 hrs before returning to camp**

As the parent, agency representative or legal guardian, I hereby give consent to St. Philip Lutheran School to provide all emergency dental or medical care prescribed by a duly licensed physician (M.D.) or dentist (D.D.S.) for my child _____ _____. This care may be given under whatever conditions are necessary to preserve the life, limb or well being of my dependent.

Child has the following allergies and/or medical condition:_____

My child may be given a pain reliever/fever reducer during school hours. _____Yes _____No

The parent or guardian will be contacted when giving any medication.

If "Yes" check the following preferences: _____Tylenol _____Advil/Motrin
Type: _____Children's Liquid _____Adult Tablets
Dosage: _____Teaspoons _____Tablets/Caplets _____Child's Weight

Other Comments:_____

_____ _____
Parent/Guardian/Agency Representative Signature Date

All persons having permission to pick up your child/children:

1. Name_____ Relationship_____ Address_____

Phone (_____) _____ Phone (_____) _____

2. Name_____ Relationship_____ Address_____

Phone (_____) _____ Phone (_____) _____

3. Name_____ Relationship_____ Address_____

Phone (_____) _____ Phone (_____) _____

Additional Information:

_____

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