



SUPER OWLS SUMMER 2016

Registration Form

Email Forms to heather@especiallyneeded.org or mail to:
 Especially Needed – Attn Heather Astuto
 SUPER OWLS SUMMER PROGRAM 2015
 10121 Waterstone Way
 McKinney, TX 75070

Select one: I am registering my child who has a special need
 I am registering a sibling of my child w/ special needs.
 Provide names of all siblings attending the 2016 summer program(s): _____

PARTICIPANT INFORMATION

Last Name _____ First Name _____ Nickname _____
 Address _____ City _____ Zip _____ DOB _____
 School _____ Grade: _____ Special Needs (if applicable) List all _____

Please include the special needs questionnaire if you are registering a child with a special need. Thanks.

PROGRAM INFORMATION: 9AM-4PM = \$225 per week. Extended hours available 8AM-9AM & 4-6PM for \$5 an hour. Payment is due on Monday prior to each week. A non-refundable deposit of \$100 is due immediately to reserve your child's spot and will go toward the cost of the camp
(Check all weeks you are registering for as well as extended hours if applicable)

- | | |
|--|--|
| ___ Week 1: June 6 – 10 ___ AM ___ PM | ___ Week 6: July 11 – 15 ___ AM ___ PM |
| ___ Week 2: June 13 - 17 ___ AM ___ PM | ___ Week 7: July 18 – 22 ___ AM ___ PM |
| ___ Week 3: June 20 - 24 ___ AM ___ PM | ___ Week 8: July 25 - 29 ___ AM ___ PM |
| ___ Week 4: June 27 – July 1 ___ AM ___ PM | ___ Week 9: Aug 1 – 5 ___ AM ___ PM |
| Week 5: July 4 – 8 NO CAMP | ___ Week 10: Aug 8 – 12 ___ AM ___ PM |
| | Week 11: Aug 15 – 19 NO CAMP |

Checks are made payable to Especially Needed with OWLS PROGRAM in memo

Parent/Guardian #1	Parent/Guardian #2
First Name:	First Name:
Last Name:	Last Name:
Home Phone:	Home Phone:
Work Phone:	Work Phone:
Email:	Email:
Preferred Method of Contact:	Preferred Method of Contact:

HEALTH INFORMATION

The information you provide here will be held in the strictest confidence. It will be kept on file in our health binder or in the possession of the program director.

Child's Doctor's Name: _____ Phone Number: _____

Allergies: ___ Yes ___ No If yes, please describe the severity of the reaction, requested accommodations and what is done to manage them _____

Does your child have any allergic reactions to sunscreen? ___ Yes ___ No

May we serve your child food and beverages(for snack time): ___ Yes ___ No

Does your child have any food allergies? ___ Yes ___ No Please list: _____

PLEASE SEND A SACK LUNCH TO SCHOOL WITH YOUR CHILD EACH DAY (a refrigerator and microwave is available).

Medications (including Inhalers): ___ Yes ___ No

If your child must take medication while attending our program, please note here. All medications must be in their original containers and be appropriately labeled. Please do not give your child's medication to them to bring to facility; medications must be received and held by the program director.

Is your child up-to-date on all state-required immunizations? ___ Yes ___ No

INSURANCE INFORMATION

Is the participant covered by family medical/hospital insurance? ___ Yes ___ No

Carrier or Plan Name: _____ Group #: _____

Address _____ City _____ State _____ Zip Code _____

Name of Insured: _____ Relationship to participant: _____
(Print child's name)

WAIVER: (YOUR REGISTRATION FORM WILL NOT BE PROCESSED UNTIL WAIVER HAS BEEN SIGNED.)

INDIVIDUAL CONTRACT

My son/daughter, (full name) _____,
has my permission to participate in the 2016 SUPER OWLS SUMMER PROGRAM at **Celebration Center – 7605 Virginia Parkway, McKinney, TX 75071**. I understand that reasonable precautions will be taken to safeguard his/her health and safety, and that I will be notified as soon as possible in any emergency. Also, I will not hold liable Especially Needed it's Council members, staff, volunteers, nor any individual lending or giving his/her private property to be used in connection with this event, for any illness or accident. If I am unable to be reached, and the occasion demands, I further authorize any treatment and hospital care advisable under the supervision of licensed medical physician. Such treatment may include x-ray, examination, anesthetic, medical, dental or surgical diagnosis.
One parent/guardian must sign for all minors.

I have read this entire Informed Consent Agreement. I fully understand it and I agree to be legally bound by it.

Signature of Parent/Guardian of Minor

Date

Participants name

FOR OFFICIAL USE ONLY

PROOF OF AGE: Yes No **Type of proof:** ID Card Birth Certificate Other: _____ **Staff Initials:** _____

PAID CAMP FEE: Yes No **Type of payment:** Cash Check **Staff Initials:** _____