



# SUPER OWLS THANKSGIVING CAMP

## Registration Form

Email Forms to [heather@especiallyneeded.org](mailto:heather@especiallyneeded.org) or mail  
SUPER OWLS PROGRAM

**Physical Location: 7605 Virginia Parkway, McKinney TX 75071**

**Mailing Address: Attn: Heather Astuto 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. **\*Special needs profile must be included with this form to complete registration. Form can be found on our website.**

Provide names of all siblings attending the OWLS program: \_\_\_\_\_

### PARTICIPANT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Nickname \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ DOB \_\_\_\_\_

School \_\_\_\_\_ Grade: \_\_\_\_\_ Special Needs (if applicable) List all \_\_\_\_\_

**PROGRAM INFORMATION:** OWLS Thanksgiving Camp will be offered on 11/25 and 11/26 from 9AM-4:00PM at \$50 per day and on 11/27 from 9AM-1PM for \$25. Payment is due at the time of registration in order to hold your spot. It is a first come, first serve basis. Thank you

A typical day at OWLS camp starts with free play during arrival time. We will then participate in circle time, performing a little morning exercise. We also offer a morning craft. After lunch we will typically relax a bit with a movie or electronic play (kids may bring Ipad if desired). We will then break to the sports area and play active fitness games such as indoor baseball, freeze tag and other fun, action games. We also have an afternoon snack.

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:

PART 2

**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 SUPER OWLS AFTERSCHOL

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:** \_\_\_\_\_