

2021 SUMMER DAY CAMP ENROLLMENT FORM

Child's Name _____ Female/Male Birthdate _____ Grade Entering _____

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Camp fee payment (Must be paid in advance; extended care fees due the beginning of following week): ___ Monthly ___ Weekly

Child lives with: ___ both parents ___ Father ___ Mother ___ Other (please list) _____

Address _____ City _____ Zip _____

Home phone/Primary cell phone _____

Name of school attending in the Fall: _____ OSLS ___ Other: _____

Please check if you are interested in further information about:

_____ School Registration for the Fall 2021

_____ Church membership at Our Savior

ALL students must have enrollment fee paid in full to complete registration.

NEW students must submit- Immunization Record

APPLICANT EDUCATIONAL INFORMATION

Do you have concerns for your child(ren) in any of the following areas? (Please write *student's initials* for all that apply)

_____ behavior _____ work habits _____ socialization _____ self-esteem

_____ reading _____ written expression _____ oral expression _____ math

Has your child(ren) ever received any therapy of the following? (Please write *student's initials* for all that apply)

___ Occupational ___ Physical ___ Speech ___ Language ___ Play

Please describe: _____

Please print:

Father/Stepfather's name _____

Address (if different from above) _____ Cell Phone _____

Mother/Stepmother's name _____

Address (if different from above) _____ Cell Phone _____

June						
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

July						
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31
August						
1	2	3	4	5	6	7
8	9	10	11	12	13	14

Circle all days you will plan to have your child(ren) at Summer Day Camp (changes to the schedule allowed up to one week prior to change).

Plan to use Extended Care: (Can adjust as needed, but please notify staff of changes as soon as possible)

___ Regularly: ___ Mornings ___: ___ - 8:00 ___ Afternoons 3:00 - ___: ___

___ Often/but not regularly: ___ Mornings ___ Afternoons

___ Occasionally

___ No plans to use it

Physician Information:

Name	Address	Phone Number
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Please check any health issues which you have noted on the accompanying most recent Student Health Registration Form, (allergies, prior medical conditions, etc.)

- Medical History As noted on the Student Health Registration Form
- Allergies As noted on the Student Health Registration Form
- Medication As noted on the Student Health Registration Form
- I am not aware of any allergy or medical issue regarding the health of my child.

Office Use:

Date Received _____
 Enroll Fee PD _____ in Full
 Check # _____
 ___ No outstanding money owed

Statement of Non-Discrimination

Our Savior Lutheran admits students of any race, color, national and ethnic origin to all the rights, privileges, programs and activities generally accorded or made available to students at the school.

Complete the Health and Emergency Contact pages unless forms were turned into the office for OSL School Enrollment this year or next year.

Student Health Registration Form

Child's
Name _____

First

Last

Grade

Date of birth

In order to ensure the health-safety of students at OSL, we are asking for any ALLERGIES or other MEDICAL CONDITIONS which should be brought to the attention of the staff.

_____ My child has NO known ALLERGIES or MEDICAL CONDITIONS

MEDICAL CONDITIONS

Please check if you have ever been told by a physician or health care professional that your child has:

_____ Asthma _____ Seizure disorder _____ Bleeding disorder _____ ADHD _____ Hearing loss
_____ Eczema _____ Diabetes _____ Skin condition _____ Heart condition _____ Vision (wears
glasses/contacts)

Please provide information as needed:

ALLERGIES* (please list specific allergy)

Food(s)

Plants

Animals

_____ Medications _____

Bees/Insects _____

Seasonal _____ Other _____

Please describe the allergic reaction and the **treatment** for **each** checked allergy.

Please notify the staff of any changes through the summer concerning any allergy or medical condition of your child.

MEDICATION

Does your child take any medication on a regular basis? Yes* _____ No _____ If yes, name of

medication(s) _____

Purpose _____

medication(s) _____

Purpose _____

Will medication be needed at school? No _____ Yes* _____ (Complete Medication Authorization Form)

*Please call to schedule a time to speak with the teacher and/or principal if specific information will impact your child, especially during the school day.

Parent signature _____

Date _____

Family Name _____
Student Name(s) _____

I, _____ certify that my child is in good health and can participate in all normal activities of the group and that I have noted any exceptions below.

I understand that reasonable measures will be taken to safeguard the health and safety of the boys/girls and that I will be notified as soon as possible in case of emergency. However, in the event of sickness or accident, I will not hold the group leaders of Our Savior Lutheran School responsible. In the case of sickness, or accident, after reasonable attempts to reach us or an emergency contact person fail, we, the undersigned parents of _____, minor(s), do hereby consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital services that may be rendered to said minor under the general special instructions of any licensed qualified physician, whether such treatment is rendered at the office of a physician or licensed hospital. It is understood that consent is given in advance of any specific diagnosis or treatment being required but is given to encourage chaperones of Our Savior Lutheran School and said physician to exercise his/her best judgment as to the requirements of such diagnosis or treatment. I authorize the calling of the physician and/or the providing of other medical services at my expense.

_____ Date _____ Signature of Parent/Guardian

Emergency Contacts (please list parent contact in priority order):

Name: _____ Circle One: Father Mother Other _____

Work Place: _____

Phone: (_____) _____ (Home/Work/Cell)

Phone: (_____) _____ (Home/Work/Cell)

email: _____

Name: _____ Circle One: Father Mother Other _____

Work Place: _____

Phone: (_____) _____ (Home/Work/Cell)

Phone: (_____) _____ (Home/Work/Cell)

email: _____

Individual(s) to notify and pick up in case of emergency if parents cannot be reached.

Please mark the box if the individual(s) is/are **also authorized to pick up child in non-emergency.**

Name Relation Phone(Cell/Home) Phone (Cell/Home)

Name Relation Phone(Cell/Home) Phone (Cell/Home)

Name Relation Phone (Cell/Home) Phone (Cell/Home)