



CAMP OLMSTED DAY CAMP REGISTRATION FORM

Child's Last Name _____ First _____ Male Female
 Parent Last Name _____ First _____ Child's Date of Birth _____
 Address _____ City, State _____ Zip _____
 Home Phone _____ Primary Language Spoken _____
 School _____ Education Regular Special (type) _____ Current Grade _____

Camp Weeks Requested:

- Week 1: June 26th – June 30th Week 3: July 10th – July 14th Week 5: July 24th – July 28th
 Week 2: July 3rd – July 6th Week 4: July 17th – July 20th Week 6: July 31st – August 3rd

Special Requests:

- Early Drop-off Time: _____ AM (additional \$75/week)
 Late Pick-up Time: _____ PM

Has your child attended Camp Olmsted before? Yes No
 How did you hear about us? Friends Flyer School Mailing Online Work Other _____
 Are you a member of the Methodist Church? (Optional) No Yes If yes, which one? _____

FAMILY DATA - For phone numbers, please circle Home, Work or Cell.

Mother's Name _____ Phone (_____) _____ (H / W / C)
 Check box if child lives with this person. Phone (_____) _____ (H / W / C)
 Father's Name _____ Phone (_____) _____ (H / W / C)
 Check box if child lives with this person. Phone (_____) _____ (H / W / C)
 Guardian's Name _____ Phone (_____) _____ (H / W / C)
 Check box if child lives with this person. Phone (_____) _____ (H / W / C)

EMERGENCY CONTACTS – Two people who will be responsible for the child if the parent or guardian is not available.

#1 Name _____ Relationship _____ Phone (_____) _____
 #2 Name _____ Relationship _____ Phone (_____) _____

PUBLIC ASSISTANCE INFORMATION – if applicable

AFDC # _____ IM CENTER _____

HEALTH INSURANCE DATA

Insurance Carrier _____ Group/Plan # _____
 ID or Policy # _____ Medicaid # _____

***PLEASE ATTACH A COPY OF CHILD'S MEDICAID CARD OR MEDICAL INSURANCE CARD TO REGISTRATION FORM**

Parent Comments

Is your child most comfortable speaking a language other than English? No Yes If yes, specify: _____

Is your child's appetite: light average hearty Is your child a vegetarian? Yes No

What are your child's favorite foods? _____ Any **food allergies**? _____

Does your child have an EpiPen? Yes No List allergies requiring EpiPen: _____

Any other allergies? _____

What other allergy medication does your child take? _____

Does your child have asthma? Yes No Does your child have an asthma pump or nebulizer? Yes No

Can your child swim? No Yes If yes, where did he or she learn? _____

Does your child like: Art Swimming Reading Hiking Singing Dancing Nature Studies
 Cooking Drama Other: _____

Does your child: Have nightmares? Sleepwalk? Wet the bed?

Does your child fear: The dark? Heights? Water? Other: _____

Has your child been away from home before? No Yes If yes, where? _____

What words would you use to describe your child? _____

Do you have any special recommendations for the care of your child? _____

Does your child have any special needs? Educational Social Emotional Other (Please Describe)

How does your child handle conflicts with adults? _____

How does your child handle conflicts with other children? _____

Is there anything else you would like to tell us about your child? _____

Signature of Parent/Legal Guardian: _____

Print Name: _____

Relationship to Child: _____ Date: _____