



After School Program Student Registration and Health Information Form

Child's Full Name: _____ Home Phone: _____

Home Address: _____

Birth Date: _____ Grade on October 1, 2017: _____ Sex: Male Female

Child resides with (check one): Father/Mother Father Only Father/Stepmother Mother Only
 Mother/Stepfather Guardian (Relationship to Student): _____

If applicant's parents are divorced or separated, which parent should receive camp communications? Please check one: Father Mother Both

Family #1 (resident parents or guardians)	
<p style="text-align: center;">Student Lives With (Circle One):</p> <p style="text-align: center;">Father Stepfather Grandfather Guardian</p> <p>Mr. _____</p> <p>Dr. _____</p> <p>Employer: _____</p> <p>Occupation: _____</p> <p>Work Phone: _____ Ext.: _____</p> <p>Cell Phone: _____</p> <p>Email Address: _____</p> <p>Responsible for camp-related decisions? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Responsible for camp communications? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p style="text-align: center;">Student Lives With (Circle One):</p> <p style="text-align: center;">Mother Stepmother Grandmother Guardian</p> <p>Mrs. _____</p> <p>Ms. _____</p> <p>Dr. _____</p> <p>Employer: _____</p> <p>Occupation: _____</p> <p>Work Phone: _____ Ext.: _____</p> <p>Cell Phone: _____</p> <p>Email Address: _____</p> <p>Responsible for camp-related decisions? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Responsible for financial bills? <input type="checkbox"/> Yes <input type="checkbox"/> No	Responsible for camp communications? <input type="checkbox"/> Yes <input type="checkbox"/> No Responsible for financial bills? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Family #2 (non-resident parent or other relative)

<p style="text-align: center;">Circle One:</p> <p style="text-align: center;">Father Stepfather Grandfather Guardian</p> <p>Mr. _____</p> <p>Dr. _____</p> <p>Employer: _____</p> <p>Occupation: _____</p> <p>Work Phone: _____ Ext.: _____</p> <p>Cell Phone: _____</p> <p>Email Address: _____</p> <p>Responsible for camp-related decisions? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Responsible for camp communications? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Responsible for financial bills? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p style="text-align: center;">Circle One:</p> <p style="text-align: center;">Mother Stepmother Grandmother Guardian</p> <p>Mrs. _____</p> <p>Ms. _____</p> <p>Dr. _____</p> <p>Employer: _____</p> <p>Occupation: _____</p> <p>Work Phone: _____ Ext.: _____</p> <p>Cell Phone: _____</p> <p>Email Address: _____</p> <p>Responsible for camp-related decisions? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Responsible for camp communications? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Responsible for financial bills? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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<p>Emergency Contacts (if parents cannot be reached)</p> <p>Name _____ Home Phone _____ Cell Phone _____</p> <p>_____</p>
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Name _____ Home Phone _____ Cell Phone

Doctor _____ Office Phone _____

Medical Information

1. Does your child have any allergies:

To foods? No Yes Please list

To drugs? No Yes Please list

To bee stings or other insects? No Yes Please list

To anything else? No Yes Please list

Explain symptoms, severity of reaction, treatment, and need for EMERGENCY TREATMENT (Epi-pen, etc.)

2. Does your child have asthma? No Yes Treatment:

3. Does your child take any daily medication at home? No Yes Name, dose, frequency:

4. Does your child need any daily medication at camp? No Yes Name, dose, frequency:

5. Has your child ever had any of the following: **(CHECK IF THE ANSWER IS YES)**

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Anorexia, bulimia | <input type="checkbox"/> Hearing difficulty | <input type="checkbox"/> Spinal curvature | <input type="checkbox"/> Bone/nerve/muscle condition |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Blood problems | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Gastrointestinal condition |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Heart condition | <input type="checkbox"/> Other |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Vision correction | <input type="checkbox"/> Over/underweight | |
| <input type="checkbox"/> Severe injury | <input type="checkbox"/> Surgeries | <input type="checkbox"/> Severe headaches | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dental problems | <input type="checkbox"/> Emotional problems | |

If "yes" to any of the above problems, explain/give dates:

(Please use back of page for additional details. Attach any medical instructions or treatment plans from your physician.)

6. Does your child have any medical or physical restrictions? No Yes If yes, please explain. (A doctor's prescription is needed for restrictions.)

Permission to Release

List all people other than the parents/guardians who may pick up your child from camp. Identification will be required before the child is released to anyone other than parents/guardians. If the person is not listed on this form, they will not be allowed to take your child. Your child's safety comes first.

Name _____ Home Phone _____ Cell Phone

Name _____ Home Phone _____ Cell Phone

Name _____ Home Phone _____ Cell Phone

Name _____ Home Phone _____ Cell Phone

Name _____ Home Phone _____ Cell Phone

Name _____ Home Phone _____ Cell Phone

List anyone who is forbidden to pick up your child from camp:

1. _____

2. _____

3. _____

4. _____

Parent/Guardian Signature: _____

Date: _____

Permission to Administer Sunscreen and First Aid

I hereby authorize St. Thomas the Apostle Episcopal Day School to apply sunscreen that I provide upon my child for outside play. I understand that I am responsible for providing the proper sunscreen for my child, will label the bottle with my child's name, and will apply sunscreen to my child before bringing him/her to camp each day. I understand that St. Thomas Summer Camp staff cannot apply sunscreen that I have not provided.

Parent/Guardian Signature: _____

Date: _____

I hereby authorize St. Thomas the Apostle Episcopal Day School to treat my child from any minor cuts or scrapes. I give permission for my child to be treated by any camp staff with items contained in the camp first aid kit, which may include:

- Antiseptics to cleanse wounds
- Antibiotic creams to prevent infection
- Bandages to prevent contamination of wound

I understand that I will be notified in writing of any treatment performed by the St. Thomas staff. I also understand that if the injury is not deemed minor by the St. Thomas staff, I will be called immediately for further instructions concerning my child's health and welfare.

Parent/Guardian Signature: _____

Date: _____

Permission for Emergency Treatment

In case of emergency, I give St. Thomas the Apostle Episcopal School personnel permission to obtain medical assistance and sign any papers necessary for emergency medical treatment for my child if I cannot be reached. This authorization does not cover major surgery, unless the medical opinion of two other licensed physicians, concurring in the necessity for such immediate treatment, is obtained prior to performance of such treatment. I realize the school cannot assume responsibility for the payment of medical fees or expenses incurred.

Parent/guardian Signature: _____

Date: _____

Medications: If your child will be taking medications of any kind during camp hours, you must fill out a St. Thomas Medical Dosage Form. This form must be turned in to the Camp Director with the medication in its original, labeled container on the first Monday of camp. All medications will be dispensed by the Assistant Camp Director as per the label and your instructions. This includes over-the-counter medications such as Tylenol, Benadryl, and vitamins. Medical Dosage Forms are available upon request.

Copy of Immunizations and Verification of Health Screenings: We must have a copy of the most recent immunization record before your child attends St. Thomas, as well as verification of the state required health screenings. Please check with your doctor or health clinic for all requirements this year. Some students will need Tetanus boosters. Varicella (chickenpox) and Hepatitis B (series of 3) need to be completed by age 12. To omit the need for a chicken pox vaccine, a statement by a parent is required showing proof that their child(ren), born on or after September 9, 1998, did have chicken pox and on what date. Hepatitis A (series of 2) is required in selected counties for children born on or after September 2, 1992.

Note: *Please attach a copy of the front and back of the health insurance card of the policy that covers your child.*

NOTICE OF NON-DISCRIMINATORY POLICY

St. Thomas the Apostle Episcopal School does not discriminate on the basis of gender, race, color, national or ethnic origin in the administration of our educational policies, employment practices, admission policies, scholarship/financial aid programs, or any other school-administered programs.