



WOODLAND PARK RECREATION
SUMMER CAMP 2011



Monday, June 27 – Friday, August 12

NAME: ENTERING GRADE: AGE:

ADDRESS: SCHOOL: SHIRT SIZE:

PARENT/GUARDIAN: HOME PHONE:

CELL: 1) 2) EMAIL:

WORK NUMBER: 1) 2):

EMERGENCY NAME: EMERGENCY #:

8:30-3:30 for 7 weeks-\$465 8:30-3:30 WEEKLY-\$115/week *Weeks of

8:30-1:00 for 7 weeks-\$380 8:30-1:00 WEEKLY-\$95/week *Weeks of

12:00-3:30 Mon.-Thurs. for 6 weeks (6/27 – 8/4) (Autism Pilot Program) - \$250

*Weeks need to be determined at the time of registration so we know how to staff our counselors

\$30 Late Fee will be charged after June 10

The above child has my permission to participate in the Woodland Park Summer Day Camp. I understand transportation to & from the camp is my responsibility and that I have to sign for permission to let my child walk. I understand that camp registration is non refundable. I understand camp hours are between 8:30am and 1pm or 8:30am and 3:30pm and camp staff is not responsible for my child beyond these time periods (except on optional field trips). I understand the camp reserves the right to expel my child for disciplinary reasons if deemed necessary. Should this occur, I will be notified in writing and my registration fee forfeited. I also understand that camp is open to Woodland Park residents only and by signing, certify that my child and I reside in Woodland Park.

Signature of parent/guardian Date

I authorize you to release my child as a walker. I give my child permission to walk to and walk home from the Woodland Park Recreation Summer Camp. I understand that camp staff is not responsible for my child's safety until he/she arrives at camp at 8:30 am or after he/she leaves at 1pm or 3:30pm.

Signature of parent/guardian Date

PLEASE SEE REVERSE SIDE FOR MEDICAL INFORMATION ->

OFFICE USE ONLY

PAID BY: CHECK # CASH TOTAL PAID \$ INTAKE BY

Proof of Residency:



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PARENT MEDICAL RELEASE FORM

Child's Name: _____ Birthdate: _____

Allergies (including food): _____

Chronic Illnesses: Nosebleeds _____ Seizures _____ Fainting _____

Eye/Vision Problems _____ Hearing Problems _____ Diabetes _____

Headaches _____ Stomach Pains _____ Other _____

Any Special Needs: _____

Any other issue camp staff should be aware of: _____

Medical Diagnosis: _____

Daily Medications: _____ Reason: _____

Family Physician: _____ Phone #: _____

I certify that all health and other information is accurate. In case of an emergency I understand every effort will be made to contact me. In the event of an emergency situation requiring medical treatment, I hereby grant permission for any and all medical attention to my child in the event of an accidental injury or illness until such time as I can be contacted. This permission includes, but is not limited to the administration of first aid or the use of an ambulance.

Signature of parent/guardian

Date