

Summer Camp Registration Form

This agreement states that all forms that apply to my family and child(ren) have been completed and submitted to the school office, and that the **non-refundable enrollment fee of \$50** for my child/family has been paid in full. (The enrollment fee is not part of the weekly fees)

1. Child's Full First **and** Last Name _____ Grade in 2018-19 _____ 3. Child's Full First **and** Last Name _____ Grade in 2018-19 _____

2. Child's Full First **and** Last Name _____ Grade in 2018-19 _____ 4. Child's Full First **and** Last Name _____ Grade in 2018-19 _____

_____ St. Michael Catholic School Student _____ St. Michael Parishioner ** _____ Other **

Camp students who are not enrolled at St. Michael Catholic School will need complete our medical form/emergency form and supply a copy of birth certificate for proof of age. **Required for acceptance into the program.

**SIGNATURE OF FINANCIAL RESPONSIBILITY

Each custodial parent and/or responsible party for payments must sign and date below. In signing below the parent/responsible party is agreeing to take financial responsibility and make regularly scheduled payments. Late or unresolved financial commitments could result in collection proceedings.

Parent/Responsible Party (1)

First Name _____ Last Name _____

Address _____ City _____

Zip _____ Cell# _____ Relationship to Child _____

Email Address: _____

Signature of Parent/Responsible Party (1)

Date

Parent/Responsible Party (2)

First Name _____ Last Name _____

Address _____ City _____

Zip _____ Cell# _____ Relationship to Child _____

Email Address: _____

Signature of Parent/Responsible Party (2)

Date

Camp Schedule

Basic information: Enrollment fee \$50 per family – Non-refundable. **Children are responsible for bringing a lunch.** Drinks will be provided. On Friday children will be allowed to purchase a special lunch from a local restaurant. The lunch menu will be posted in late May. Children in the Preschool through kindergarten should bring a change of clothes. (A minimum of 10 children per age group is needed to offer the class. Groups are available on a first come basis.)

Weekly Rates: \$175 per week (due on Friday the week prior to attending) –
Payment for the week of 6/10-6/14 is due by May 31st.

Hours: Camp Hours: 8AM – 3PM **Before Care 7AM – 7:30 AM **After Care: 3PM – 5PM

Camp Dates: Please check: The week your child/children will be in attendance and grade level/s

Theme: Pets and Vets

**Special Activity this week Puppetry for all grades

_____ 6/10 – 6/14 _____ Pre – KN _____ 1st – 3rd _____ 4th – 7th

Theme: Space

**Special Activity this week Archery for grades 4 – 7 from 9 – 11

** Special Activity this week Puppetry for all grades

_____ 6/17 – 6/21 _____ Pre – KN _____ 1st – 3rd _____ 4th – 7th

Theme: Closed for Summer Break

XXX Closed 6/24 – 7/5

Theme: Dinosaurs

**Special Activity Fossil fun

_____ 7/8 – 7/12 _____ Pre – KN _____ 1st – 3rd _____ 4th – 7th

Theme: Totus Tuus (Grades KN – 6)

**Special Activity this week includes Oceans for Pre-School and Seventh grades

7/15 – 7/19 _____ Pre – KN _____ 1st – 3rd _____ 4th – 7th

Theme: Fairy Tales

**Special Activity this week includes Drama for grades 3 – 7 from 1 – 3PM and Band Camp grade 7 from 10 – 12

**Special Activity this week include Game/History/Art Club with Fr. Jenkins for grades 5 – 7

_____ 7/22 – 7/26 _____ Pre – KN _____ 1st – 3rd _____ 4th – 7th

Extended Care

\$25 per week for Before and/or After Care. No daily or hourly rate. Please check if you need this service.

_____ My child/children will need before and/or after care. I understand the cost is \$25 per week regardless of the number of hours or days the service is used.

2019-2020 Student Summer Camp Medical Information

To Be Filled out by Non-St. Michael School Families (One per child)

Student Name _____

LAST

FIRST

MIDDLE

Please check "Yes" or "No" for all that apply:

Vision Problems Yes No Glasses Yes No Hearing Problems Yes No Hearing Aids Yes No

Physical Handicap Yes No If Yes, Explanation _____

Asthma Yes No Medication: _____ Diabetes Yes No Medication: _____

Seizure Disorder Yes No Type: _____ Medication: _____

Life Threatening Allergies List: _____ Epi Pen Yes No

Other medications explain _____

Permission for Analgesics and Benadryl: Please mark which medications you give permission to be administered at school as needed:

*** Parents will supply the medication in original bottles

- Acetaminophen (i.e., Tylenol) every 4 hours as needed. *Dose based on age/weight*
- Ibuprofen every 6 hours as needed. *Dose based on age/weight*
- Benadryl (Diphenhydramine HCL) 12.5 mg/5ml (1 teaspoon): *Administer for bee/wasp sting. Dose based on age/weight*

ADDITIONAL EMERGENCY/MEDICAL INFORMATION:

In case of an emergency involving your child, it is the policy of the Archdiocese of Indianapolis Catholic Schools to render first aid treatment while contacting parent(s)/guardian(s) for further instructions. In the event that the parent(s)/guardian(s) cannot be contacted, school officials will contact 911. Please check each box below to indicate your approval/permission.

- I grant permission to school personnel to send my child to the hospital for treatment.
My hospital preference is: _____
- In case of emergency, I authorize the school to take my child by ambulance to the nearest hospital even though the hospital may not be my first choice.
- I give the school personnel authorization to treat my child in the absence of the school nurse.
- Insurance: Yes No Insurance Provider (if applicable) _____

Family Doctor _____ Phone Number _____

Family Dentist _____ Phone Number _____

Parent/Guardian Name (1) _____ Emergency Number _____

Parent/Guardian Name (2) _____ Emergency Number _____

When parents/ guardians cannot be reached, who should we contact	Name (1) _____	Relationship to child _____
	Home/Cell # _____	Work # _____
	Name (2) _____	Relationship to child _____

Parent/Guardian Signature _____ Date _____