

**Centre Greene January Camp
January 2nd to 6th, 2012
Registration**



DAYS ATTENDING (please check all that apply)

Monday(2 nd)	Tuesday(3 rd)	Wednesday(4 th)	Thursday(5 th)	Friday(6 th)

CHILD

Name of Child: _____

Age: _____

Date of Birth: _____

Address: _____

Telephone Number: _____

School and Grade: _____

PARENT(S)

Parent #1 Name: _____

Parent #2 Name: _____

Address: _____

Address: _____

Telephone # (day): _____

Telephone # (day): _____

Telephone # (home): _____

Telephone # (home): _____

Telephone # (cell): _____

Telephone # (cell): _____

Email: _____

Email: _____

NAME TO BE PUT ON TAX RECEIPT: _____

IN CASE OF EMERGENCY

1. Name: _____

2. Name: _____

Telephone #: _____

Telephone #: _____

PEOPLE AUTHORISED TO PICK UP CHILD

1. _____ 2. _____
3. _____ 4. _____

MEDICAL INFORMATION

Medicare #: _____ Expiry date: _____

Does your child have any...

Allergies?: _____

Medical Conditions we should know about?: _____

Behavioral Difficulties?: _____

Other?: _____

I give permission for my child's photo to be used in promotional material.

yes

no

I Authorize Centre Greene to take necessary action in relation to the health of my child.

Signature _____ Date _____