

Centre Greene Spring Break Camp

Registration



DAYS ATTENDING (please check all that apply)

Monday	Tuesday	Wednesday	Thursday	Friday

CHILD

Name of Child: _____

Age: _____

Date of Birth: _____

Address: _____

Telephone Number: _____

School and Grade: _____

PARENT(S)

Mothers Name: _____

Address: _____

Telephone # (day): _____

Telephone # (home): _____

Telephone # (cell): _____

Email: _____

Fathers Name: _____

Address: _____

Telephone # (day): _____

Telephone # (home): _____

Telephone # (cell): _____

Email: _____

NAME TO BE PUT ON TAX RECEIPT: _____

IN CASE OF EMERGENCY

1.Name: _____

Telephone #: _____

2.Name: _____

Telephone #: _____

PEOPLE AUTHORISED TO PICK UP CHILD

1. _____

3. _____

2. _____

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 _____

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