



# Children's Center for Therapy and Learning

2124 NE 123<sup>rd</sup> Street, Suite 204, North Miami, FL 33181

PH:305.895.0444 \* Fax:305.895.0490 \* www.Therapyandlearning.com

## Summer Camp Preliminary Registration Form

### REGISTRATION FORM

Submit one form per participant. Complete sections I, II, and III

#### I. General Information

Name (Last, First, MI)

Address (Street, City, State, Zip)

Birth date \_\_\_\_\_ Age \_\_\_\_\_

#### Parent/Guardian Information

Registrant is in the custody of:  Both Parents  Mother Only  Father Only Other: \_\_\_\_\_

Mother/Guardian Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Alt Phone \_\_\_\_\_

Father/Guardian Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Alt Phone \_\_\_\_\_

Emergency Contact (other than Parent/Guardian)

Relationship \_\_\_\_\_ Daytime Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Alt Phone \_\_\_\_\_

**Parent/Guardian Permission:** As a legal guardian I give permission for the registrant to participate in all phases of camp activities. I understand and agree to cooperate with all regulations. I will not allow registrant to attend if not in good physical condition. In an emergency, when the undersigned or other person named cannot be reached, I give permission for the camp authorities to take any emergency measures deemed appropriate. It is understood that all reasonable efforts will be made to contact the parent/guardian.

I understand that when participating in activities the registrant may be photographed for print, video or electronic imaging. I understand that the images may be used in promotional and fundraising materials, news releases and other published formats, and will be the sole property of the Children's Center for Therapy and Learning.

Check if registrant **MAY NOT:**  Be photographed for Children's Center publicity purposes

**MAY NOT:**  Participate in \_\_\_\_\_ activity.

(eg rock climbing, zip line, astronaut training, etc.)

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_



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## Medical Information:

Known Allergies: \_\_\_\_\_

Sensory Concerns: \_\_\_\_\_

Special Dietary Resctrictions: \_\_\_\_\_

If food is used and/or consumed in an activity can the child participate?  Yes  No

## Authorization of Treatment:

I hereby give my permission to the medical personnel selected by the camp director to order treatment and necessary transportation for my child. In the event I cannot be reached in an emergency, I hereby give my permission to the physician to secure and administer treatment, including authorization for my child named above.

Parent Initials \_\_\_\_\_

What Goals and Objectives would you like to see your child improve upon during camp?

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What concerns do you have about your child's development that you would like to have addressed by the camp staff?

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What home programs would you like to see developed for your child?

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What areas of development would you like testing in?

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