City of Allen
2014 Camper Information Form

Child's Name:_____ Age:_____ Gender: M F

Address:_____ City:_____ Zip Code:_____

Parent/Guardian: (A)_____ Relationship:_____ DL#_____

Home Phone #: (A)_____ Work Phone #:_____ Cell Phone #:_____

Email Address: (A)_____

Parent/Guardian: (B)_____ Relationship:_____ DL#_____

Home Phone #:(B)_____ Work Phone #:_____ Cell Phone# :_____

Does Your Child Speak English (Circle One) YES Mostly NO

If No, What Language Does Your Child Speak Fluently _____

Can Your Child Understand English (Circle One) YES Mostly NO

If No, What Language Does Your Child Understand _____

Emergency Contacts other than a parent / Permission to Pick up Child

Name:_____ DL #: _____ Home #: _____ Work #: _____

Name:_____ DL #: _____ Home #: _____ Work #: _____

Waivers

_____Int. I'm aware camp will be watching G/PG rated children's movies(A list of movies available upon request).

_____Int. The City of Allen may_____ /may ***NOT***_____ administer medication brought from home in accordance with the instructions given with the medication.

_____Int. Photos may be taken during camp and those photos may be used in marketing or advertising materials.

_____Int. In consideration of your accepting my child's entry to the City of Allen Summer Day Camp, I hereby, for myself, my child, my heirs, executors and administrators, waive and release any and all rights and claims for damages I or my child may have against the City of Allen, its employees or any volunteers working with the program. The risks involved in respect to such a program are fully understood.

_____Int. I received the PARENT HANDBOOK, I will read and comply with the information inside it.

Permission to Travel

_____Int. I understand there will be day trips scheduled during my child's participation, and hereby authorize my child's participation in these activities. I authorize the City of Allen and its contractors to transport my child to any and all planned field trips.

Authorization for Medical Treatment

_____Int. In the event I cannot be reached to make arrangements for medical treatment, I authorize the City of Allen employees to administer first aid and/or transportation to the nearest hospital.

Name of Licensed Physician:_____ Phone #:_____

Address:_____ City:_____ Zip Code:_____

1) Please list any health problems or conditions that should be known to the staff (i.e.- allergies, medications).
2) Please list any behavioral disorders such as ADHD, Oppositional Defiant Disorder, or anxiety. ***(Optional)***

Parent/Guardian Signature:_____ Date: _____