Alliance Française de Las Vegas

SUMMER CAMP 2019 - REGISTRATION FORM

PARENT INFORMATION

Mother ☐ Father ☐ Guardian ☐ First Name: _____Last Name:_____

Number: _____Street: _____ Apt #: _____

City: _____ State: _____ Postal code:_____

Parent #1 Home Tel:_____Office:_____Cell:_____

Parent #2 Home Tel:_____Office:_____Cell:_____

E-mail:_____

CAMPER INFORMATION

First Name:_____Last Name:_____

D. O. B.: _____/_____/_____ *(month/day/year)*

Is there anything you would like to inform us about regarding your child's medical history (include allergies, pre-existing illnesses,

behavioral and emotional concerns)? _____

_____

_____

Emergency contact name:_____Relationship to family:_____ Phone number:_____

Physician's name:_____ Physician's phone number:_____

Arrangements for pick-up / drop-off at the Alliance Summer Camp

By parent(s): Yes ☐ No ☐

Names of other people allowed to pickup your child (if any): _____

Relationship to child: _____

Please note that your child will only be released to the people listed above on presentation of a State-issued ID.

Home phone:_____ Office: _____ Cell:_____

Child travels by herself/himself (allowed to leave after signing out) Yes ☐ No ☐

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Camper's Background in French (if any)

_____

_____

Please indicate your expectations or your concerns regarding this camp:

_____

_____

REGISTRATION

Half Day (8:30-12:30) $189 **Full Day (8:30-3:30) $269**

What week(s) would you like to register your child(ren) in:

☐ **Week 1 (June 3 - 7)**	☐ **Half day**	☐ **Full day**
☐ **Week 2 (June 10 –14)**	☐ **Half day**	☐ **Full day**
☐ **Week 3 (June 17 – 21)**	☐ **Half day**	☐ **Full day**
☐ **Week 4 (June 24 – 28)**	☐ **Half day**	☐ **Full day**
☐ **Week 5 (July 8 - 12)**	☐ **Half day**	☐ **Full day**
☐ **Week 6 (July 15-19)**	☐ **Half day**	☐ **Full day**
☐ **Week 7 (July 22-26)**	☐ **Half day**	☐ **Full day**

Extended hours: Please sign up at Montessori Visions Academy at front desk the first day of your child(ren) camp

☐ 5% Member Discount (Write you Membership number) #_____

☐ 5% discount for early registration (before May 24, 2019)

REFUNDS, CANCELLATIONS AND TRANSFERS

PLEASE NOTE THAT ALL CANCELLATIONS AND CHANGES ARE SUBJECT TO THE POLICIES BELOW, WITHOUT EXCEPTION.

- All cancellations must be made in writing (i.e. e-mail or letter) to the AFLV.
- Refunds can only be issued for sessions cancelled more than 1 week prior to the first day of camp. A $30.00 cancellation fee will apply (per child and per session cancelled.) No refunds will be granted for withdrawals announced less than 1 week prior to the start of the session.
- Refunds for medical reasons can only be granted upon presentation of a medical certificate to the AFLV.
- Pro-rated refunds cannot be granted if a child cannot attend the camp some days due to sickness or any other personal circumstance. Requests for transfers will be accepted up to 1 week prior to the first day of a camp session, provided there is sufficient room in the preferred camp session.

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RELEASE AND AUTHORIZATION

- I understand that the participation in any children's activity can result in possible injury or danger. I will not hold the Alliance Française de Las Vegas (AFLV) nor Montessori Visions Academy and their staff liable in case of harm or damage arising or sustained by my child during the period of the camp.
- Parents have to drop off and pick up their children at the camp premises (1905 E. Warm Springs Road, Las Vegas 89119). The AFLV and Montessori Visions Academy are not responsible for children off the premises. In case of absenteeism, parents are asked to write to AFLV (info@aflasvegas.org). Children are not allowed to leave except with written permission. Parents who choose the after-hour service must pick up their children at 5:30pm at the latest as the school will close at this time. Pick-up after 5:30pm will result in an extra charge.
- Parents are required to adhere to the dietary requirements of the facility: no nuts or nut butters, no soda, candy, gum allowed.
- We require that all young people attending AFLV Summer Camp demonstrate respect for each other and for their counselors. This includes respect for each other's safety and respect for each other's feelings. Politeness, attitude and behavior must conform to these expectations. The AFLV reserves the right to expel students whose attitude presents a nuisance or a danger to the spirit of the group.
- I hereby give permission for my child to participate in all activities.
- I understand that neither the AFLV, nor Montessori Visions Academy nor their staff are responsible for damage or loss of personal belongings during the program.
- I understand that descriptions of program are subject to change before and/or during the camp season without prior notice. I have read all the above information and agree to abide by the condition outlined.

Name of child:	Name of parent / guardian:
Date:	Signature:

Photo and multimedia release
I do grant the AFLV permission to:

- Display photos and videos of my child taken during the camp activities within the premises of the school.

  ☐ YES ☐ NO

- Use photos and videos of my child taken during the camp activities in AF promotional materials such as brochures, flyers, website etc.

  ☐ YES ☐ NO

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PARENTS' REQUEST TO ADMINISTER MEDICATION AT CAMP

Name of child: _____ D.O.B:___/____/____

In order for my child to receive medication at camp, I agree to the following:

- **All prescription and non-prescription medication will have a physician's signed order (see form below).**
- **The non-prescription medication will be in the original sealed container with the label intact. Child's name will be put on the container in a position that does not obscure the label.**
- **The medication will be brought to the CAMP by an adult.**
- **The physician will be called if a question arises about the child's medication.**
- **I confirm that the first dose of this medication (except for Epi-Pens) has been given without problems.**

Having read the above conditions, I request that an Alliance Française de Las Vegas teacher administer the medication as prescribed by the physician below. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at camp.

Signature of Parent/Guardian:_____ Date:_____

Relationship to child _____

Phone Number: (H) _____ (W) _____ Other_____

Address _____

_____

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PARENT'S AUTHORIZATION IN CASE OF EMERGENCY

Name of child: _____ D.O.B:___/____/____

I authorize the Alliance Française de Las Vegas to call 911 if my child injures herself/himself or if she/he falls sick.

Signature of Parent/Guardian: _____Date:_____

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PHYSICIAN'S SIGNED ORDER FOR MEDICATION AT CAMP - ONE MEDICATION PER FORM

Diagnosis:_____

Name of Medication: _____

Dosage:_____

Route:_____

Time of Administration at Camp:_____

_____

_____

If PRN, for what symptoms? _____ **How often?**_____

Please list any specific precautions personnel should be aware of or any unusual effects that might be observed. _____

_____

_____

_____

Child has allergies to the following medications:_____

Services should begin (Date)_____**and terminate (Date)**_____

FOR INHALER, EPI-PEN, AND INSULIN ONLY:

___ It has been determined that this child is able to self-administer and carry inhalant medication or Epi-pen and has been trained to its use, including knowing when the medication is to be used.

___ It has been determined that this child is able to self-administer insulin.

___ This child should not self-administer inhalant medication, insulin, or Epi-pen.

Physician's signature: _____ **Date:**_____

(Original signature and stamp)

Physician's Name (Printed): _____

Address:_____

Telephone Number: _____