CAMP ALL*STARZ

WWW.CAMPALLSTARZ.COM

Business Office: 2517 Highway 35, Building H – Suite 205, Manasquan, NJ 08736 * Phone 732-282-0150 * Fax 732-282-0151
Camp Site: Holy Innocents School, 3455 West Bangs Avenue, Neptune, NJ 07753 * Phone 732-282-0150 * Fax 732-922-2848

2016 REGISTRATION FORM

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Camper Name:	**Date of Birth:**
Street Address:	**Age:** **Sex:** □ **Male** □ **Female**
City, State, Zip Code:	**Home Phone Number:**
Parent/Guardian Names:	**Relationship:**
Cell Phone:	**Work Phone:**
EMAIL (*Required* CAMP NOTICES AND UPDATES WILL BE SENT VIA EMAIL)	**I do NOT use email** □

SESSIONS (MONDAY-FRIDAY, 9:00AM-3:00PM)

□ **June 27 –July 1 ($325)** □ **July 5 – July 8 ($275)** □ **July 11 – July 15 ($325)**

□ **July 18 – July 22 ($325)** □ **July 25 – July 29 ($325)** * **$100 non-refundable deposit with application**

***Weeks cannot be changed**

***No refunds (exception for special circumstances)** *** Balance due June 1**

□ **PLEASE ENROLL MY CHILD FOR EXTENDED DAY ($9 PER HOUR)**

□ **MORNING CARE** □ **AFTERCARE**

IN CASE OF EMERGENCY, PLEASE NOTIFY (*MUST PROVIDE TWO*, OTHER THAN PARENT/GUARDIAN)

1	**Name:**	**Relationship:**
	Street Address:	**Home Phone:**
	City, State, Zip Code:	**Cell Phone:**
2	**Name:**	**Relationship:**
	Street Address:	**Home Phone:**
	City, State, Zip Code:	**Cell Phone:**

EMERGENCY MEDICAL INFORMATION

Has or is subject to: (Check)

- □ Asthma
- □ Diabetes
- □ Convulsions
- □ Fainting Spells
- □ High Blood Pressure
- □ Contact Lenses
- □ **Allergy or reaction to any medicine, food, plant, animal or insect toxin.**
- □ Any other condition that may require emergency or special care, medication, or knowledge.
- □ Heart Trouble

Explain, if necessary:

OTHER HEALTH HISTORY (PAST/PRESENT)

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Date of most recent physical examination:___________________________

Primary Physician: Phone:

Address:

HEIGHT: **WEIGHT:**

CURRENT MEDICATIONS

Medic

Medication	Dosage	Frequency	Adverse Reaction	To be administered at Camp
				☐ yes * ☐ no
				☐ yes * ☐ no
				☐ yes * ☐ no

***I authorize Camp ALL*STARZ to administer the medications indicated above to my child during camp hours (medication must be labeled and stored in original prescription container). Signature______________________________ Date______________________**

IMMUNIZATIONS

PLEASE ATTACH A COPY OF YOUR CHILD'S IMMUNIZATION RECORD FROM YOUR DOCTOR

Is there any additional information about your child that would help us to provide a positive experience at Camp ALL*STARZ ? (e.g. behavioral issues, physical limitations)

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AUTHORIZATION TO PHOTOGRAPH/VIDEOTAPE

I authorize Camp ALL*STARZ to to photograph/videotape my child during his/her participation at the program. I understand these photographs may be used for promotional purposes and that my child will not be identified by name. I understand that I can withdraw this authorization at any time and the photographs/videos will not be used. (**This authorization does NOT include use of photographs for the Camp ALL*STARZ to website and that special permission will be requested for that purpose).** ☐ **Yes** ☐ **No**

FIELD TRIP AUTHORIAZTION

☐ **I GIVE PERMISSION FOR MY CHILD TO TAKE OFF-SITE FIELD TRIPS.**

I understand that my child may be discharged from the program due to behavior determined by the Camp Director to be too disruptive or interferes with the progress of other participants. In the event this happens, the fee will not be returned.
I understand that I am financially responsible for any damages that my child causes to the facilities used during the summer program.
I understand that my child will not be released from the camp site to anyone other than the parent/guardian without written permission. Identification must be provided before the child will be released.

MEDICAL AUTHORIZATION

To the best of my knowledge, this history is correct and complete. I know of no reason to restrict applicant's activity, and give my permission for treatment and participation in all activities except as specifically noted herein. In the event that I cannot be reached in an emergency, the Director or Supervisor in charge has my permission to use his or her discretion in securing medical aid and the physician has my permission to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above. It is my understanding that neither the camp nor the person responsible for obtaining medical aid will be held responsible for the expense incurred.

Date: **Signature:** **Camp Director:**