SAINT JOSEPH SCHOOL
WAKEFIELD

# February Vacation Camp Week

## of February **19** – 2**2**, 201**9**

Today's Date _____

1. Student Information
(List all students who will attend; attach additional sheet if necessary)

| Participant First Name | DOB | Current Grade | Medications | Allergies |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |

Please indicate days. (Minimum of two days.)

Mon N/A Tues_____ Wed_____ Thurs_____ Fri_____

2. Parent/Guardian Information.
Check best (first) phone to call in case of emergency.

Name: _____ Name: _____

Address: _____ Address: _____

☐ Home Phone: _____ ☐ Home Phone: _____

☐ Work Phone: _____ ☐ Work Phone: _____

☐ Cell Phone: _____ ☐ Cell Phone: _____

3. Student Pick-up Information: ☐Pick-up Only

Please list people who have your permission to pick-up your child from the program.

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

4. Emergency Contact Information

List two people we may contact who know your child and can take full responsibility should you be unavailable.

Name: _____ Home Phone: _____ Work Phone: _____

Name: _____ Home Phone: _____ Work Phone: _____

Notes

a. Full Day 8:00AM – 5:30PM $65 Per Day
b. NO Cancellation / NO Refund Policy.
c. Space is limited and is first come first serve.
d. Sign up only. NO drop in service
e. Parent/Guardian Consent for Photographs and Internet Use.
f. Payment due in full with registration.
g. All camps will run with sufficient enrollment only.

I give my consent to the Saint Joseph School to photograph my child and to use such pictures and/or stories in connection with any of their work without consideration of compensation of any kind, and I do release Saint Joseph School from any claims whatsoever which may arise in said regards.

There will be no refund when school is not in session or for student illness or pro-rating for absenteeism.

In case of an emergency injury or illness, I authorize the Program to call the paramedics. As legal guardian of the above listed student, a minor, I authorize the school representative designee to consent to any x-ray, examination, anesthetic, medical or surgical diagnosis, treatment, and/or hospital care to be rendered upon the advice of any licensed physician and/or dentist. The program is not responsible for personal items.

I have read and understand the above.

Parent/Legal Guardian Signature_____ Date_____