Centre Greene March Break Camp
Registration

DAYS ATTENDING (please check all that apply)

Monday	Tuesday	Wednesday	Thursday	Friday

CHILD

Name of Child:_____
Age:_____
Date of Birth: _____
Address:_____
Telephone Number:_____
School and Grade: _____

PARENT(S)

Parent #1 Name:_____
Address:_____
_____
Telephone # (day):_____
Telephone # (home):_____
Telephone # (cell):_____
Email:_____

Parent #2 Name:_____
Address:_____
_____
Telephone # (day):_____
Telephone # (home):_____
Telephone # (cell):_____
Email:_____

NAME TO BE PUT ON TAX RECEIPT:_____

IN CASE OF EMERGENCY

1.Name:_____
Telephone #:_____

2.Name:_____
Telephone #:_____

PEOPLE AUTHORISED TO PICK UP CHILD

1._____ 2._____

3._____ 4._____

MEDICAL INFORMATION

Medicare #:_____ Expiry date:_____

Does your child have any...

Allergies?:_____

_____

Medical Conditions we should know about?:_____

_____

Behavioral Difficulties?:_____

_____

Other?:_____

_____

I give permission for my child's photo to be used in promotional material.

yes ☐ no ☐

I Authorize Centre Greene to take necessary action in relation to the health of my child.

Signature_____Date_____