PD Day Camp Registration

Please Highlight or Circle Dates you would like to register for:
PD Day Camp Dates: October 9th, October 23rd, November 9th, November 10th, November 12th, November 13th, January 29th, February 1st, February 11th, February 12th, March 5th, May 7th, May 20th, May 21st

Child's Name:_____ Child's Preferred Name:_____
Date of Birth:_____ Gender: M___ F____
Mother's Name:_____ Father's Name:_____
Mother's Address:_____ Father's Address:_____
Legal Land Location:_____ Legal Land Location:_____
Mother's Home Phone:_____ Father's Home Phone:_____
Mother's Cell Phone:_____ Father's Cell Phone:_____
Mother's Work Phone:_____ Father's Work Phone:_____
Parent Email Address:_____
1. PLEASE LIST AN EMERGENCY CONTACT IN THE CASE THAT THE PARENTS CANNOT BE REACHED:
Name:_____ Home Phone:_____
Cell Phone:_____ Address:_____
OR Legal Land Location:_____
(Must be provided if you don't have a street address)
Relationship to Child:_____
2. LIST ANY ALLERGIES THAT YOUR CHILD HAS:_____
(please fill out the Allergy Instructions Form in this package)
3. LIST ANY MEDICAL CONDITIONS THAT YOUR CHILD HAS:_____
_____
(please fill out the Medical Treatment Release Form in this package)

HEALTH RECORD

Child's Physician:_____ Address:_____
Physician's Phone #:_____ Health Care Number:_____
Are your child's immunizations up to date? Yes___ No___

EMERGENCY MEDICAL TREATMENT

I/We, _____, give consent to the staff of Eagles Nest Before and After School Care to provide or allow for medical treatment to be
given to my child.
I/We understand that if an emergency should occur, the Program will make every effort to contact me (parents or guardians). Should they be unsuccessful, I authorize any and all employees of Eagles Nest to sign for medical treatment for my child, including transportation by an ambulance if necessary.
Signature:_____
Date:_____

FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT

I/We, give permission to share necessary personal information (name, phone number) with other staff and parents for the purpose of program coordination.
Signature:_____
Date:_____

ALLERGY INSTRUCTIONS

Child's Name:_____
My child is allergic to:_____
This allergy is: Mild___ Moderate___ Severe___
Please explain your child's symptoms:_____
_____
_____
I entrust Eagles Nest Staff to do the following upon an allergic reaction (Please specify steps):
_____
_____
_____
_____
Signature:_____
Date:_____

MEDICAL TREATMENT INSTRUCTIONS AND RELEASE

Child's Name:_____
Child's Medical
Condition:_____
What triggers the condition?_____
_____
Does your child need medication administered? Yes___ No___
(You must fill out an Individual Medication Record for your child if medication needs to be administered) Eagles Nest Staff will administer antidote/allergy/seizure medication on an emergency basis.
Should a life threatening emergency occur, is there any medical treatment that you would not wish your child to have? (Please
explain):_____
_____
I understand that it is my responsibility to inform Eagles Nest staff if there are any changes to the above information.

ANY QUESTIONS OR CONCERNS PLEASE EMAIL US AT eaglesnestoosc@gmail.com