2022 SUMMER ADVENTURE CAMP

Child's Name _____Female/Male Birthdate _____Grade Entering ___

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Camp fee payment (Must be paid in advance; extended care fees due the beginning of following week): __ Monthly __ Weekly

Child lives with: __both parents __Father __Mother __Other (please list) _____

Address _____City _____Zip _____

Home phone/Primary cell phone_____

Name of school attending in the Fall: ____ OSLS ___ Other: _____

Please check if you are interested in further information about:

_____ School Registration for the Fall 2022

_____ Church membership at Our Savior

ALL students must have enrollment fee paid in full to complete registration.

NEW students must submit - Immunization Record

APPLICANT EDUCATIONAL INFORMATION

Do you have concerns for your child(ren) in any of the following areas? (Please write *student's initials* for all that apply)

___ behavior ___ work habits ___ socialization ___self-esteem

___ reading ___ written expression ___ oral expression ___math

Has your child(ren) ever received any therapy of the following? (Please write *student's initials* for all that apply)

__Occupational __Physical __Speech __Language __Play

Please describe: _____

Please print:

Father/Stepfather's name _____

Address (if different from above) _____ Cell Phone_____

Mother/Stepmother's name_____

Address (if different from above) _____ Cell Phone_____

May/June						
		31	1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

July						
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24 31	25	26	27	28	29	30
August						
	1	2	3	4	5	6

We are reserving this space for your child at Adventure Camp. If your child/children will not be attending, you will be charged unless we are notified one full week prior. <u>Payment is due prior to your child attending the week of camp</u>. Your child will not be allowed to attend until all prior fees are up-to-date.

Plan to use Extended Care: (Can adjust as needed, but please notify staff of changes as soon as possible)

___Regularly: __ Mornings __:___ - 8:00 __ Afternoons 3:00 - __:___

___Often/but not regularly: __ Mornings __ Afternoons

___Occasionally

___No plans to use it

Physician Information:

_____

Name Address Phone Number

Please check any health issues which you have noted on the accompanying most recent Student Health Registration Form, (allergies, prior medical conditions, etc.)

- ☐ Medical History As noted on the Student Health Registration Form
- ☐ Allergies As noted on the Student Health Registration Form
- ☐ Medication As noted on the Student Health Registration Form
- ☐ I am not aware of any allergy or medical issue regarding the health of my child.

Office Use:
Date Received_____
Enroll Fee PD_____ in Full
Check # _____
___ No outstanding money owed

<u>Statement of Non-Discrimination</u>

Our Savior Lutheran admits students of any race, color, national and ethnic origin to all the rights, privileges, programs and activities generally accorded or made available to students at the school.

Complete the Health and Emergency Contact pages unless ***forms were turned into the office for***
OSL School Enrollment this year or next year.

Student Health Registration Form

Child's Name_____
First Last Grade Date of birth

In order to ensure the health-safety of students at OSL, we are asking for any ALLERGIES or other MEDICAL CONDITIONS which should be brought to the attention of the staff.

_____**My child has NO known ALLERGIES or MEDICAL CONDITIONS**

MEDICAL CONDITIONS

Please check if you have ever been told by a physician or health care professional that your child has:
____ Asthma ____ Seizure disorder ____ Bleeding disorder ___ ADHD ____ Hearing loss
____ Eczema____ Diabetes ____ Skin condition ____ Heart condition ____ Vision (wears glasses/contacts)
Please provide information as needed:

_____

_____

ALLERGIES* (please list specific allergy)

Food(s) _____

Plants _____

Animals _____Medications_____

Bees/Insects _____

Seasonal_____Other_____

Please describe the allergic reaction and the **treatment** for **each** checked allergy.

_____

_____

Please notify the staff of any changes through the summer concerning any allergy or medical condition of your child.

MEDICATION

Does your child take any medication on a regular basis? Yes* ____ No ____ If yes, name of

medication(s)_____

Purpose_____

medication(s)_____

Purpose_____

Will medication be needed at school? No____ Yes*____ (Complete Medication Authorization Form)

*Please call to schedule a time to speak with the teacher and/or principal if specific information will impact your child, especially during the school day.

_____ _____
Parent signature Date

Emergency Procedure and Medical Release Form

Family Name _____
Student Name(s) _____

I, _____ certify that my child is in good health and can participate in all normal activities of the group and that I have noted any exceptions below.

I understand that reasonable measures will be taken to safeguard the health and safety of the boys/girls and that I will be notified as soon as possible in case of emergency. However, in the event of sickness or accident, I will not hold the group leaders of Our Savior Lutheran School responsible. In the case of sickness, or accident, after reasonable attempts to reach us or an emergency contact person fail, we, the undersigned parents of _____, minor(s), do hereby consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital services that may be rendered to said minor under the general special instructions of any licensed qualified physician, whether such treatment is rendered at the office of a physician or licensed hospital. It is understood that consent is given in advance of any specific diagnosis or treatment being required but is given to encourage chaperones of Our Savior Lutheran School and said physician to exercise his/her best judgment as to the requirements of such diagnosis or treatment. I authorize the calling of the physician and/or the providing of other medical services at my expense.

_____ _____
Date Signature of Parent/Guardian

Emergency Contacts (please list parent contact in priority order):

Name: _____ Circle One: Father Mother Other_____

Work Place: _____

Phone: (____) _____(Home/Work/Cell)

Phone: (____) _____(Home/Work/Cell)

Email: _____

Name: _____ Circle One: Father Mother Other_____

Work Place: _____

Phone: (____) _____(Home/Work/Cell)

Phone: (____) _____(Home/Work/Cell)

Email: _____

Individual(s) to notify and pick up in case of emergency if parents cannot be reached.
Please mark the box if the individual(s) is/are **also authorized to pick up child in non-emergency**.

☐ _____ _____ _____ _____ _____
Name Relation Phone (Cell/Home) Phone (Cell/Home)

☐ _____ _____ _____ _____ _____
Name Relation Phone (Cell/Home) Phone (Cell/Home)

☐ _____ _____ _____ _____ _____
Name Relation Phone (Cell/Home) Phone (Cell/Home)