

# CAMP AMY MOLSON – REGISTRATION FORM – 2012

PLEASE MAIL TO: 5165 SHERBROOKE ST. WEST, #210  
MONTREAL, QUEBEC H4A 1T6

1 2 3

No. \_\_\_\_\_

<b>CHILD'S FAMILY NAME:</b> _____	<b>PLEASE ATTACH PHOTO HERE.</b>												
<b>CHILD'S FIRST NAME:</b> _____													
<b>SEX:</b> <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE													
<b>Parent's Name(s):</b> _____ <b>Foster Parent(s) Name:</b> _____													
<b>Address:</b> _____ <div style="display: flex; justify-content: space-between; font-size: small; margin-top: 5px;"> <span>NO.</span> <span>STREET</span> <span>APT. #</span> <span>CITY</span> <span>PROV.</span> <span>POSTAL CODE</span> </div>													
<b>Email: Please Print</b> _____ @ _____													
<b>Telephone:</b> _____ <div style="display: flex; justify-content: space-around; font-size: small; margin-top: 5px;"> <span>HOME</span> <span>WORK</span> <span>OTHER</span> </div>													
<b>Child lives with:</b> <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparents <input type="checkbox"/> Aunt/Uncle <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other													
<b>Emergency Contacts:</b> The <b>TWO emergency contact individuals</b> must be available during the duration of the camp and should be asked if she/he is willing to serve in this role.													
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-top: 1px solid black; width: 30%; text-align: center;">NAME</td> <td style="border-top: 1px solid black; width: 40%; text-align: center;">RELATIONSHIP</td> <td style="border-top: 1px solid black; width: 30%; text-align: center;">PHONE</td> </tr> <tr> <td style="border-bottom: 1px solid black; height: 20px;"></td> <td style="border-bottom: 1px solid black; height: 20px;"></td> <td style="border-bottom: 1px solid black; height: 20px;"></td> </tr> <tr> <td style="border-top: 1px solid black; text-align: center;">NAME</td> <td style="border-top: 1px solid black; text-align: center;">RELATIONSHIP</td> <td style="border-top: 1px solid black; text-align: center;">PHONE</td> </tr> <tr> <td style="border-bottom: 1px solid black; height: 20px;"></td> <td style="border-bottom: 1px solid black; height: 20px;"></td> <td style="border-bottom: 1px solid black; height: 20px;"></td> </tr> </table>		NAME	RELATIONSHIP	PHONE				NAME	RELATIONSHIP	PHONE			
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<b>Child's Medicare Card #:</b> _____	<b>(Exp)</b>	/	_____	<b>Date of Birth</b>	/	_____	/	_____
MONTH / YEAR		DAY / MONTH / YEAR						

<b>Parent marital status:</b>	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
<b>Source of income:</b>	<input type="checkbox"/> Employed <input type="checkbox"/> Social Assistance <input type="checkbox"/> UIC <input type="checkbox"/> Loans/bursaries <input type="checkbox"/> Pension <input type="checkbox"/> Other
<b>Gross annual income:</b>	<input type="checkbox"/> < \$22,999 <input type="checkbox"/> \$23,000-\$27,999 <input type="checkbox"/> \$28,000-\$34,999 <input type="checkbox"/> \$35,000-41,999 <input type="checkbox"/> \$42,000-47,999 <input type="checkbox"/> \$48,000-\$53,999 <input type="checkbox"/> \$54,000-\$59,999 <input type="checkbox"/> \$60,000-\$69,999 <input type="checkbox"/> \$70,000 +
<b>Languages spoken by child:</b>	<input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other: _____
<b>Child's Ethnic Origin:</b>	<input type="checkbox"/> French <input type="checkbox"/> British <input type="checkbox"/> Italian <input type="checkbox"/> Haitian <input type="checkbox"/> Arab <input type="checkbox"/> Chinese <input type="checkbox"/> Greek <input type="checkbox"/> African <input type="checkbox"/> South Asian <input type="checkbox"/> West Indian <input type="checkbox"/> Portuguese <input type="checkbox"/> Latino, Central/South American <input type="checkbox"/> Other: _____

**Total # of people in household (including parents/ guardian & children):**

**School & grade of child:**

**Will your child be taking the bus up to camp?**

Yes

No

**Has your child ever been away form home for more than one week?**

Yes

No

**How does your child feel about going to camp?**

Very excited

Anxious

Doesn't want to go

**Does your child know anyone attending CAM?**

Yes

No

**How did you hear about CAM?**

Word of mouth

School

CLSC

Gazette

Flyer

Other: \_\_\_\_\_

**Session Requested:**

1<sup>st</sup> ( June 29-July 13)

2<sup>nd</sup> (July 17 – July 31)

3<sup>rd</sup> (August 3-17)

**Who will be paying the camp fees? Tax receipt in name of:**

**If you would like to receive a tax receipt, please ensure you fill out this box.**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

No. \_\_\_\_\_ Street \_\_\_\_\_ Apt. \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_ Social Insurance Number: \_\_\_\_\_

**OFFICE ONLY**

**Regular Program:**

240    270    315    375    430    490    550    630    810    960    REG

**L.I.T. Program:**

290    320    365    425    480    540    600    680    860    1010    REG

**Payment and Refund Policy**

Personal cheques are not accepted.

In the event that the camper leaves the camp on account of serious illness, a pro rata refund will be made and in the event the camper is dismissed by the camp directors for misconduct, the camp fees will NOT be refunded.

Refunds will be issued in September following camp, when two weeks notice for cancellation is received or when a medical certificate is received. Registration fees are not refundable.

**MEDICAL INFORMATION**

**IS THE CHILD SUBJECT TO ANY OF THE FOLLOWING:**

- Bed Wetting       Ear Problems       Asthma       Constipation       Sunburn
- Sensitive Skin       Hearing Impaired       Speech Impaired       Fear of Water       Hyperactive
- ADHD       ADD       Autism       Learning Disability       Anaphylactic Shock
- Glasses       Nightmares       Other \_\_\_\_\_

**IS THE CHILD ALLERGIC TO ANY OF THE FOLLOWING:**

- Penicillin       Antibiotics       Food       Bee Stings       Insect Bites
- Other \_\_\_\_\_

**IS THERE ANY FOOD YOUR CHILD SHOULD NOT EAT?** \_\_\_\_\_

**HAS YOUR CHILD HAD CHICKEN POX?**       Yes       No

**IS THERE ANY MEDICAL REASON WHY YOUR CHILD MAY NOT BE ABLE TO PERFORM ANY CAMP ACTIVITIES?** Please explain: \_\_\_\_\_  
\_\_\_\_\_

**PHYSICIAN'S NAME:** \_\_\_\_\_ **TELEPHONE #:** \_\_\_\_\_

**HAS YOUR CHILD HAD THE FOLLOWING VACCINATIONS?**

Vaccination	No	Yes	Date/ Last Vaccination
D.P.T. (Diphtheria, Pertussis, Tetanus)	<input type="checkbox"/>	<input type="checkbox"/>	
Polio Vaccine (Sabin, Salk)	<input type="checkbox"/>	<input type="checkbox"/>	
M.M.R. (Measles, Mumps, Rubella)	<input type="checkbox"/>	<input type="checkbox"/>	
Hemophilus (H.I.B.)	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis (B)	<input type="checkbox"/>	<input type="checkbox"/>	
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	
Meningococcal	<input type="checkbox"/>	<input type="checkbox"/>	
HINI	<input type="checkbox"/>	<input type="checkbox"/>	

**WILL YOUR CHILD BE TAKING ANY MEDICATION (prescription/ non prescription), WHILE AT CAMP?**

Medication	Medical Reason	Dosage	Specific Time Taken

## ADDITIONAL INFORMATION

**ARE THERE ANY TRICKS TO SHARE THAT WORK WITH YOUR CHILD?**

**WHAT DO YOU HOPE YOUR CHILD LEARNS FROM THEIR STAY AT CAM?**

**HAVE THERE BEEN ANY SIGNIFICANT FAMILY CHANGES IN THE PAST 12 MONTHS?**

**e.g. Divorce, death, birth, family move**

### PERMISSIONS/CONSENT:

While every effort will be made to reach me, in the event where it is impossible for the camp directorate to obtain my consent in the case of a medical emergency, I authorize the camp to proceed with the necessary medical interventions(s), in my name, to secure proper treatment for my child. In the case of serious or life-threatening emergency, I authorize the physician selected by the camp directorate to proceed with the necessary medical intervention(s) including injection, anesthesia, surgery, or hospitalization in order to secure proper treatment for my child.

- I authorize the camp first aid technician/or person assigned to health center duty to dispense any of the following non-prescription types of medications: acetaminophen, ibuprofen, anti-nauseant, antihistamine, anti-inflammatory, cough syrup, topical antibiotic, Polysporin eye/ear drops.
- I will also notify the camp in writing if my child has any changes in his/her medical condition between the time I send this medical information form and the opening day of the camp session.
- Photographs of your child may be taken at camp for promotional and/or advertising as well twitter and facebook use. If you consent to the use of your child's photo for these purposes.
- I give permission for the Camp Amy Molson staff to survey my child during and after the session(s) to question about the camp. All information is voluntary, anonymous, and confidential. These questions will be used in order to improve our summer program.

**PLEASE REMEMBER TO INCLUDE THE \$30.00 REGISTRATION FEE AND PHOTO**

Signature \_\_\_\_\_ Date \_\_\_\_\_