BKLA
SUMMER CAMP

SUMMER CAMP REGISTRATION FORM

Please print

Today's Date: _____ Registered by: _____

PARTICIPANTS INFORMATION

Grade as of Sept. 2024: _____ Registration Date: (mm/dd/yyyy)_____

School Child Attends: _____ Birth date: _____ Age: _____ Sex: ☐ M ☐ F

Street address: _____ Apt/Floor: _____ Home phone number: _____

P.O. box: _____ City: _____ State: _____ ZIP Code: _____

1. Parent/Guardian Full Name: _____

Relationship to participant: _____ Email Address: _____ Cell phone: _____

2.Parent/Guardian Full Name: _____

Relationship to participant: _____ Email Address: _____ Cell phone: _____

Alternative Phone Numbers: _____

Home: _____ Work: _____ Daytime: _____

EMERGENCY CONTACT

1. Name of Individual: _____ Relationship to child: _____

Email Address: _____ Telephone Number: _____

2. Name of Individual: _____ Relationship to child: _____

Email Address: _____ Telephone Number: _____

3. Name of Individual: _____ Relationship to child: _____

Email Address: _____ Telephone Number: _____

List Any Individuals Who CANNOT Pick Up Child

Name(s): _____ Additional Name(s): _____

Relationship to Child: _____

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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Participant's Name:

Last:_____ First:_____ Middle: _____

Date of Birth: _____ Previous or referring doctor: _____

Date of last physical exam: _____ Pharmacy: _____ Phone: _____

PERSONAL HEALTH HISTORY

Childhood Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

PAST MEDICAL HISTORY

Condition/Disease	Year Diagnosed	Other(s)	Year Diagnosed
☐ Hypothyroidism (low thyroid)			
☐ Asthma			
☐ Diabetes			
☐ Depression or Anxiety			
☐ Heart Problems			
☐ Migraine			

SURGERIES

Year	Reason	Hospital

OTHER HOSPITALIZATIONS

Year	Reason	Hospital

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CHECK ANY/ALL THAT APPLY TO YOU

☐ Occupational Therapy ☐ Physical Therapy ☐ None ☐ Asthma

Allergies: _____

Others: _____

Speech/Language: _____

IEP/Others: _____

ALLERGIES TO MEDICATIONS/FOOD/OTHER

Name the Drug/Food	Reaction You Had

PHYSICIAN INFORMATION

Physicians Name _____ Physicians Telephone: _____

Dental Office: _____ Dental Office #: _____

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REGISTRATION TYPE

CAMP DATES

4 WEEKS ☐ JULY 1ST-JULY 26TH ☐ JUNE 29TH-AUGUST 23RD

6 WEEKS ☐ JULY 1ST-AUGUST 9TH

8 WEEKS ☐ JULY 1ST-AUGUST 23RD

Lunch: ☐ Opt Out Trips: ☐ Opt In ☐ Opt Out

CHILD START DATE: _____ CHILD END DATE: _____

NOTES:

_____

_____

_____

_____

_____

_____

AGE GROUP

☐ Pee-Wee Patrol (3-5 Years)

☐ Mini Minions (6-7 Years)

☐ Camp Fire Crew (8-9 Years)

☐ Team Titans (10-11 Years)

☐ Senior Squad (12-15 Years)

EXTENDED DAY

☐ Early AM (7:30am-8:30am) ☐ Late PM (4pm-6:30pm) ☐ N/A

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TEE SHIRTS

Circle which size applies to your child

Youth Sizes ☐ XS ☐ SMALL ☐ MEDIUM ☐ LARGE ☐ X-LARGE

Adult Sizes ☐ XS ☐ SMALL ☐ MEDIUM ☐ LARGE ☐ X-LARGE

PAYMENT METHOD

Tuition: $ _____ Deposit: _____ Discount: _____

Payment Plan: _____

Total: $ _____ Balance Due: $ _____

☐ Check ☐ Credit/Debit ☐ ACS/HRA ☐ 1199 ☐ TWU

☐ Early AM ☐ Late PM

Card Type: _____ Expiration Date: _____

Card Number: _____

Card Authorization Signature x _____

PARENT/GUARDIAN

I authorize BKLA to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

By signing your name electronically you are agreeing that your electronic signature is the legal equivalent of your manual signature.

_____ _____

Participant's Name (Please Print) Date

_____ _____

Parent's or Guardian's Name (Please Print) Parent or Guardian's Signature X