



Summer Enrichment  
Program  
Activity Permission and  
Health Form

Student's Name \_\_\_\_\_ M/F \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Grade (Fall '08) \_\_\_\_\_ Age on 6/01/2008 \_\_\_\_\_ yrs. \_\_\_\_\_ mos. Birth Date \_\_\_\_\_

Parent/Guardian(s) \_\_\_\_\_

Parent/Guardian 1 Work Phone \_\_\_\_\_ Parent/Guardian 2 Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Notify in an emergency contact if parent/ guardian is not available:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_

Health Insurance Info. (Group #, ID #) \_\_\_\_\_

## Health History

Check all that apply and give details (Dates, further information, etc.)

- |  |  |
|--|--|
| <input type="checkbox"/> Frequent Ear Infections _____     | <input type="checkbox"/> Asthma (describe): _____                |
| <input type="checkbox"/> Heart Defect/ Disease _____       | <input type="checkbox"/> Insect Sting Allergies (specify): _____ |
| <input type="checkbox"/> Convulsions _____                 | _____  |
| <input type="checkbox"/> Diabetes _____                    | <input type="checkbox"/> Drug Allergies (specify): _____         |
| <input type="checkbox"/> Bleeding/ Clotting Disorder _____ | <input type="checkbox"/> Food Allergies (specify): _____         |
| <input type="checkbox"/> Hypertension _____                | <input type="checkbox"/> Operations/ Serious Injuries _____      |
| <input type="checkbox"/> Mononucleosis _____               | <input type="checkbox"/> Disabilities (specify): _____           |
| <input type="checkbox"/> Psychiatric Treatment _____       | <input type="checkbox"/> Activities to be Limited _____          |
| <input type="checkbox"/> Chicken Pox _____                 | <input type="checkbox"/> Dietary Modifications (specify) _____   |
| <input type="checkbox"/> Measles _____                     | _____  |
| <input type="checkbox"/> German Measles _____              | <input type="checkbox"/> Other Conditions (specify): _____       |
| <input type="checkbox"/> Mumps _____                       | _____  |
| <input type="checkbox"/> Hay Fever _____                   | _____  |

## Medications

Will your child require medication while at camp? \_\_\_\_ yes \_\_\_\_ no

*If yes, then please contact the camp for a medication form which must be on file in order for us to dispense medication to your child while at camp. This form is required for us to dispense any prescribed or over the counter medications (aspirin, cough drops, etc.) which your child may require while in our care.*

Call Today to Reserve Your Spot!

305-854-3516

## Examinations

Date of last physical exam: \_\_\_\_\_

**This item MUST be filled out or your form will be returned.**

## Medical Insurance Carrier Information

Insurance Co. \_\_\_\_\_ Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

## Health Permission

This health history is correct so far as I know and my child \_\_\_\_\_, described herein, has permission to engage in all prescribed camp activities except as noted. In the event that we cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for my child named above.

Signature of Parent or Legal Guardian ✕ \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

**Must have BOTH signatures and date or form will be returned**

## Activity Permission

My child \_\_\_\_\_ has permission to engage in all activities instructed by Closing the Gaps Learning Center as part of the program(s) in which he/she enrolled, and may travel to and from all activity locations by bus or school van as required by the program schedule. All necessary safety precautions will be taken.

Signature of Parent or Legal Guardian ✕ \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

**Must have BOTH signatures and date or form will be returned**

# Closing the Gaps Learning Center Summer Enrichment Program

## Indemnity Agreement

In consideration of **Closing the Gaps Learning Center** permitting my child

\_\_\_\_\_ to participate in any and all of **Closing the Gaps Learning Center's** summer program activities and related trips I, (Parent/ Legal Guardian)

\_\_\_\_\_ hereby voluntarily release, waive and forever discharge Closing the Gaps Learning Center from responsibility. Therefore I relinquish any and all actions for demands against the above named sponsors that arise as a result of any accidental injuries and/or damages sustained by the above named child, parent, guardian, or personal representative participating in any and all activities related to Closing the Gaps Learning Center's Summer Enrichment.

Parent/Guardian Signature:

\_\_\_\_\_ Date: \_\_\_\_\_

I grant permission for my child to participate in all of the camp's trips. I permit the publication of any summer camp photo of my child.

Parent/Guardian Signature:

\_\_\_\_\_ Date: \_\_\_\_\_