



### COMPLETE 1 SHEET PER CHILD

#### Camper Information

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Gender: Female Male DOB \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

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

School Name \_\_\_\_\_ Grade \_\_\_\_\_

#### Student Medical Information

Allergies or Dietary Restrictions \_\_\_\_\_

Medical Conditions \_\_\_\_\_

Does your child take any medications that need to be administered at the center?  Yes  No

MEDICATION REASON \_\_\_\_\_

*(Dosing instructions must be provided by a physician.)*

My child(  is  is not immunized.

I confirm that my child has been examined by a doctor within the last 12 months.  Yes  No

Additional Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### Other Student Information

- Yes No Does your child has any special needs or restrictions of which the center should be aware?
- Yes No Does your child use any special equipment, such as breathing machine, wheelchair, hearing aid, braces, etc.?
- Yes No Does your child need extended one-to-one care?
- Yes No Does your child function at the age level of other children in his or her age group?
- Yes No Can your child effectively communicate his or her needs?
- Yes No Is your child able to fully participate in all activities offered in center?
- Yes No Does your child require any assistance at meal or snack time?
- Yes No Does your child require and/or desire any accommodations or modifications to fully and equally enjoy and participate in the center's group care setting?
- Yes No Does your child rest in the middle of the day?
- Yes No Is your child toilet trained?