Scholar AthELITE Summer Camp Registration

Child's Name	Mother's Name	Day Phone	Father's Name	Day Phone
Other Parent Name	Relationship to Child		Day Phone	
Other Parent Name	Relationship to Child		Day Phone	
Home Address	City	State	Zip	Home Phone
Cell Phone	Cell Phone	E-mail		

Please review carefully and fill-out as detailed as possible. Thank you

Camper Name:_____

Boy_____Girl_____Birthdate_____Age_____

EMERGENCY & MEDICAL HISTORY • If parents are unavailable,

Contact: _____

Relationship:_____

Phone: (_____)_____

Doctor Name: _____

Doctor Phone: (_____)_____

Has the camper had any recent injury, illness or infectious diseases?

Yes_____No_____What?_____

Is the camper up to date on immunizations? Yes_____ No_____

Date of last Tetanus shot _____

Is camper on medications? Yes_____ No_____

Name of medication:_____Reason:_____

Name of medication:_____Reason:_____

Does the camper have any special needs? (allergies, asthma, diabetic, etc.)

Yes_____No_____What?_____

_____

Fill this out ONLY if you registered for Pick 2/3 Days a week Camp
Choose what days you would like to attend camp
Monday_____Tue_____Wed_____Thur_____Fri_____

Lunch Meal Plans: $6.00 per meal
Monday-Pizza_____
Tuesday-Sub w/ chips (ham/turkey)_____
Wednesday-Pizza_____
Thursday-Sub w/ chips _____
Friday-Pizza_____
Drink included with each meal
You are welcome to bring your own lunch to camp

_____

☐ ***BY CHECKING HERE, you are consenting to the use of your electronic signature in lieu of an original signature on paper. Your agreement to use an electronic signature with us for any documents will continue until such time as you notify us in writing that you no longer wish to use an electronic signature.***

Please check the camps you plan on attending:

WK1:Science O. ☐ Ceramics ☐ TV Tech ☐ Team Adv ☐
WK2:D.I.Y ☐ JR Chef ☐ Lost Worlds ☐ Soccer ☐
WK3: D.I.Y2 ☐ Stop Mot. ☐ Forensics ☐ Basketball ☐
WK4:Brush N Stuff ☐ Photo ☐ STEM ☐ Baseball ☐
WK5:STEM #2 ☐ Fashion Design ☐ Print M. ☐ Football ☐
WK6:JR Chefs ☐ Build IT! ☐ Graphic Design ☐ Cheer ☐

Medical Insurance Information:

Please list the name of your medical carrier:_____

Policy #:_____

Do you have medical insurance: Yes___☐___No___☐_____

Payment Method: ONLY for Offline payments

Check #_____ $_____

Credit Card: Visa_____ Master Card_____ Discover Card_____ AMEX_____

Cardholder Name:_____

Credit Card #_____

EXPDate:_____ CVC # _____ (three digit number on back of card)

Cardholder Signature:_____

Date:_____

Make checks payable to: Scholar AthELITE Company

Mail to: PO Box 2214 Orange, CA 92859 _____

I have read and agree to all conditions for registration policies, general information, and methods of payment. I have given complete and accurate medical information on campers current health status and campers prior health history. I further agree to allow Scholar AthELITE Company to provide routine health care, administer medication and treatments, arrange for transportation, and, in an emergency, administer treatment as deemed appropriate. Date:_____

Parent/Guardian Signature:_____