



Summit School Summer Camp 2017



****Please send in registration form as soon as possible in order to hold your child's spot. Payment can be made on or prior to the start of camp.**

Date: _____

Student's name: _____ Birth date: _____ Age: _____

Does your child require transportation? YES _____ NO _____

Pick in the am Address: _____ City & Prov.: _____ Postal code: _____

Drop off in the PM Address (If different): _____ City & Prov.: _____ Postal code: _____

Home Phone no.: _____ Email: _____

Father/Guardian: First name: _____ Last name: _____

Mother's/Guardian: First name: _____ Last name: _____

Teacher's name: _____ Social Worker: _____

Emergency contact: _____ Relation: _____ Phone no.: _____

Father's work phone no.: _____ Mother's work phone no.: _____

Father's cell: _____ Mother's cell: _____

Medication Yes No Medication name: _____ Dosage per day: _____

Syndrome Yes No Describe: _____

Activity Restrictions Yes No Describe: _____

Allergies Yes No Describe: _____

Please check off the sessions child will attend (minimum of 3 weeks)*: (IF LESS THAN 3 WEEKS THE COST PER WEEK WILL BE 325\$)*

July 3- July 7 July 10 – July 14 July 17 – July 21 July 24 – July 28 July 31- Aug. 4

Number of weeks _____ x \$300 = \$ _____

Number of weeks _____ x \$325 = \$ _____

SOCIAL INSURANCE NUMBER OF THE INDIVIDUAL CLAIMING THE TAX CREDIT: (please check one box)

Father's S.I.N. _____

Mother's S.I.N. _____

I am applying to an outside agency for funding: Yes: _____ (Fill out information below) No: _____ (Enclose payment)

Agency name: _____

Address: _____
Number / Street App.# City/Province Posta Code

Contact person: _____ Telephone #: _____

Signature of parent/guardian: _____