

Please Fax Completed Form to 301.387.6550



Reservation Dates: Start: _____ Finish: _____

Childs Name: _____ Age: _____ Date of Birth: _____

Parents Name: _____ Phone # (home): _____

Address (home): _____

City: _____ State: _____ Zip: _____

Phone# (local): _____ Phone# (cell): _____

Email: _____

Please circle one:	ADVENTURE CAMP	KID'S NIGHT OUT	DROP IN CHILDCARE
--------------------	-----------------------	------------------------	--------------------------

***Drop In Childcare Guests do not have to complete the activities release agreement.**

Names of persons other than parents authorized to pick up child: _____

Emergency Contacts: Primary: _____ Phone #: _____

Health History

Family Physician: _____ Phone #: _____ Date of last Physical: _____

<u>Does you child have any of the following?</u>	Yes	No	Comments:
Vision Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Hearing Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Speech / Language Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Physical Illness or impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Mental, Emotional or Behavioral Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Health condition which may require care or emergency action (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Child is currently taking medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
This child is in good physical & mental health. Child is free of any & all communicable disease & may participate in all activities. If not, list all restrictions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

Child is enrolled in a Maryland Public School? Name of Maryland School: _____

If not, please provide a copy of immunization record