Family Support Center
435 Columbian Street
Weymouth, MA 02190

VACATION CAMP REGISTRATION FORM

(Please print neatly)

Name: ___________________________ DOB: ___________ Grade ______ Gender: M F

Address ____

Mother's Name: _________________________________ Home Phone: _________________

Address: ________________________City: ______________ Zip Code: ________________

Place of Employment: ______________________ Work Hours: ________Work Phone: ________

Employment Address:____

Cell Phone: ____________________ Email: _______________________________________

Father's Name: _________________________________ Home Phone: ___________________

Address: ________________________City: ______________ Zip Code: _________________

Place of Employment: ______________________ Work Hours: ________Work Phone: ________

EmploymentAddress:____

Cell

Phone: ____________________ Email: _______________________________________

Guardian's Name _________________________ Home Phone _____________ Address:

________________________City: ______________ Zip Code: _________________

Place of Employment: ______________________ Work Hours: ________Work Phone: ________

EmploymentAddress:____

Cell Phone: ____________________ Email: _______________________________________

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EMERGENCY CONTACT PERSONS

FIRST

Name: ___________________________________ Phone Number ____________________

Address: _______________________City: __________________ Zip Code: ____________

Relationship to Child: _________________________

SECOND

Name: ___________________________________ Phone Number ____________________

Address: _______________________City: __________________ Zip Code: ____________

Relationship to Child: _________________________

PERSONS AUTHORIZED TO PICK UP YOUR INDIVIDUAL

(OTHER THAN PARENTS)

Name: _______________________________________ Phone Number:___________________

Address:_____________________________ City: _____________ Zip Code:________________

Relationship to Child: __________________________

Name: _______________________________________ Phone Number:___________________

Address:_____________________________ City: _____________ Zip Code:________________

Relationship to Child: __________________________

Name: _______________________________________ Phone Number:___________________

Address:_____________________________ City: _____________ Zip Code:________________

Relationship to Child: __________________________

Are there any persons who are not permitted to pick up individual child?

1. ____________________________ Relationship to Child __________________________

2. ____________________________ Relationship to Child __________________________

Doctor's Name ___________________ Doctor's Phone Number ________________________

Dentist's Name ___________________ Dentist's Phone Number ________________________

1st Choice of Hospital _______________ Phone Number ___________________________

Address ________________________ City ___________________ Zip Code ______________

Health Insurance Information ______________________ Policy Number ______________

If Physician cannot be reached, what action should be taken _______

call emergency hospital _____ other

explain____

ADDITIONAL INFORMATION

Any Known Allergies:
Please describe the allergy in detail below, including reaction to allergen:

____

Does participant need support for toileting? ( ) yes ( ) no

If yes, please describe: ____

____

How does the participant ambulance? Please check what applicable to your individual

Independent _____ Need assistance _______ Wheelchair_______ Walker_______

If applicable, please describe any physical restriction for your individual.

____

Please describe individual's response to anxiety and/or frustration? For example, does s/he withdraw, cry, yell, refuse to participate, wander, run, kick, become aggressive, etc?

____

____

Effective ways to respond to any behavior: (If your individual has a Positive Behavioral Support Plan in school or at home, please provide us a copy so we may be as consistent with the individual.

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AUTHORIZATION RELEASE

Authorization to take pictures:

The parent of the above registered child gives authorization allowing the individual to be photographed, and the photos to be used in the promotion of the South Shore Support Services.

Parent Signature ______________________________Date_____________

Transportation Authorization:

The parent of the above registered child gives authorization allowing the child to be transported to and from South Shore Support Services.

Parent Signature _________________________________Date_____________

Insurance Information: The individual is covered by family's medical insurance ( ) yes ( ) No

Please include a copy of your insurance card; copy both sides of the card so information is readable.

Medical Insurance Co. Name____

Group Number ______________________________Policy Number _______________________

Subscriber Name: ____

Medical Release

I hereby give my permission to the South Shore Support Services staff to seek medical treatment (private physician or hospital) or transportation for my child should any emergency arise. I understand that a conscientious effort will be made to locate me or my spouse before any action will be taken.

Parent's Signature ____________________________________ Date_____________

Medications:

If the individual on any medications that he/she is required to take during the day?
( ) yes ( ) no

If so, individual is required to be able to take medication only with a verbal reminder from family support coordinator.

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AGREEMENT CONTRACT

______ payment may be made by check (please write your individual's name on your check), credit card or cash. Cash payments must be made at the South Shore Support Services. Payment will be due on Monday, June 20.

South Shore Support Services

I give my permission for the South Shore Support Services to use without limitation or obligation, photographs, film footage, or tape recordings which may include my or my children's image or voice for the purpose of promotion or interpreting South Shore Support Services.

Individual's Name:____

Parent(s)Signature:____

Date:__________________