



Believe in Us

ARC 2017 Camp Casper Week Only REGISTRATION



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Child (ren)'s Name(s):

1) _____ Age: _____

2) _____ Age: _____

3) _____ Age: _____

Parents/Guardians:

Name(s) _____

Address _____ City _____

Phone Numbers:

Home: _____

Cell: Mom: _____ Dad: _____

Work: Mom: _____ Dad: _____

Check box if we may share your email with JDCF

EmailAddress: _____

Pick up/Transportation(Only fill out if you are transporting wit ARC).

Person(s) allowed to pick-up children when parents/guardians are not available:

Name: _____ Ph: _____ Relationship: _____

Name: _____ Ph: _____ Relationship: _____

Emergency Contact:

When parents/guardians cannot be immediately reached, this person is also allowed to pick up

Name: _____ Ph: _____ Relationship: _____

Preferred Physician/Hospital _____

Does your child (ren) have any known allergies/health concerns: _____

Does your child(ren) take any routine medications _____ Name: _____

Parent/Guardian Signature _____ Date: _____