Brain Bytes Academy

2019 SUMMER CAMP PROGRAM APPLICATION

*** REGISTER EARLY !!! SPACE IS LIMITED !!! REGISTRATION ACCEPTED FIRST COME, FIRST SERVE !!! ***

CAMP SITE is located at 133 Main St, Lincoln Park, NJ
WEEK of August 19-23

K - 8th Grades
FULL CAMP 8:30 AM – 4:30 PM
Child's Grade in
Last Name__________________ First Name ___________________Sept. 2019 ___ School _______ D/O/B _____ M/F __
Address __________________________________ Town _______________ Phone ________________________
Primary Contacts:
1. Parent/Guardian Name______________________ Relation ____________ Phone Number _________________
2. Parent/Guardian Name______________________ Relation ____________ Phone Number _________________
Email/s (Please distinguish b/w letters & numbers) 1. ____
2. ____
Emergency Contact Information (IF the above contacts cannot be reached):
1. Name ____________________________ Relation _______________ Phone Number ___________________
2. Name ____________________________ Relation _______________ Phone Number ___________________
The following additional people are authorized to pick up my child:
1. Name ____________________________ Relation _______________ Phone Number __________________
2. Name ____________________________ Relation _______________ Phone Number __________________
3. Name ____________________________ Relation _______________ Phone Number __________________
I hereby grant the Brain Bytes Academy permission to use my child's image for press releases and/or Montville Township social media? Yes _____ OR No _____
PARENT/GUARDIAN SIGNATURE ____ DATE __________
My child has my permission to participate in this program.
I understand that the Brain Bytes Academy DOES NOT provide accident insurance.
PARENT/GUARDIAN SIGNATURE ____ DATE __________
SPACE IS LIMITED !!! NO GUARANTEE OF PLACEMENT !!!
$349.00 Weekly Fee for FULL Day 8:30AM -4:30 PM
OR $199.00 Half Day Camp Fee 8:30 am- 12:30 pm or 12:30pm - 4:30 pm
10% Sibling Discount
FOR OFFICE USE (2/7/19): Fee Paid _____ Cash Check Received By _____ Date _____ Program # 858

Brain Bytes Academy

2019 SUMMER CAMP MEDICAL HISTORY & RELEASE FORM

Child's Grade in
Last Name_______________________ First Name _______________________Sept. 2019 _____ D/O/B ______
M/F __
Has your child been under medical care within the past year? Yes ____ No _____
If yes, for what & reason?
____
Is your child allergic to penicillin or any other drug? Yes ____ No _____
If yes, what?
____
If your child has allergies, please give a detailed explanation of any reactions your child has had in the past to include symptoms and what kind of medical treatment was required (example: pediatrician visit, ambulance to hospital, etc., and the year it occurred)
____
Is there any medication to be taken in certain emergencies? Yes ____ No _____
If yes, what?
____
* If your child requires an Epi-Pen to be left with the Director, please label all with the child's first and last name and place in a
* Zip Lock bag to be handed directly to your Camp Director the first day of camp through the last day of camp.
Please CIRCLE any and all your child is subject to:
Fainting Headaches Tonsillitis Stomach Upsets Abdominal Pains Cramps, Where? _____________
Frequent Sore Throats Sinus Trouble Bronchitis Constipation Hay Fever Eczema
Asthma Ear Infections Convulsions Serious Ivy, Oak or Sumac Poisoning
Other ____
Please CIRCLE if your child has any of the following:
Lung Problems Kidney Problems Heart Problems Hernia Epilepsy Diabetes
Other ____
Does your child have any limitations or special needs? Yes _____ No _____
If yes, please indicate so we may better serve your child
____
____
Please describe any reasonable modifications that may be needed due to a disability that your child may have to better enjoy this program:
____
EMERGENCY TREATMENT RELEASE: This authority is granted ONLY after reasonable effort has been made to reach me or my emergency contact. As a Parent/Guardian of the child listed above, who is attending Brain Bytes Academy program, I herewith authorize the treatment by a qualified and licensed medical doctor in the event of a medical emergency, which in the opinion of the attending physician may endanger my child's life, cause disfigurement, physical impairment, or undue discomfort if delayed.
PARENT/GUARDIAN Signature ____ Date __________
Family Physician ____ Phone # ________________________

 FOR OFFICE USE (2/7/19): Received By __________ Date __________