



Camp4Kids

2026-2027 REGISTRATION FORM

Date Received: _____
by: _____

Student Name:	
☐ Male ☐ Female	Date of Birth:
Elementary School:	
Address: _____ City _____	
State: _____	Zip Code _____
Phone Number:	
Email:	

PARENT/FAMILY OCCUPATIONS & PLACE OF BUSINESS:

Guardian: _____
ADDRESS: _____
City _____ State _____ Zip _____
WORK: (____) _____ CELL: (____) _____
EMAIL: _____

Guardian: _____
ADDRESS: _____
City _____ State _____ Zip _____
WORK: (____) _____ CELL: (____) _____
EMAIL: _____

ADDITIONAL PARENTAL INFORMATION (IF REQUIRED)

Guardian: _____
ADDRESS: _____
City _____ State _____ Zip _____
WORK: (____) _____ CELL: (____) _____
EMAIL: _____

Guardian: _____
ADDRESS: _____
City _____ State _____ Zip _____
WORK: (____) _____ CELL: (____) _____
EMAIL: _____

EMERGENCY CONTACT INFORMATION:

Emergency Contact Name: _____ Relationship: _____ Phone: (____) _____
Emergency Contact Name: _____ Relationship: _____ Phone: (____) _____
Emergency Contact Name: _____ Relationship: _____ Phone: (____) _____

AUTHORIZATION FOR PICK-UP (ID REQUIRED) – MUST SHOW A VALID PICTURE ID

1. NAME: _____ RELATIONSHIP: _____ PHONE# (____) _____
2. NAME: _____ RELATIONSHIP: _____ PHONE# (____) _____
3. NAME: _____ RELATIONSHIP: _____ PHONE# (____) _____

SHARE INFORMATION WITH: _____

The following people **CANNOT** or **DO NOT** have permission to pick up from after school program:

NOT AUTHORIZED _____

NOT AUTHORIZED _____

Parent(s) Signature _____ Date: _____

STUDENT HEALTH INFORMATION

Please list health problems:

Please list physical limitations _____

Please list allergies (including food): _____

Please list regular medications: _____

Family Physician: _____ Phone: (____) _____

Family Dentist: _____ Phone: (____) _____

Please Check One: ☐ **Health Insurance** ☐ **Medicaid/Welfare** ☐ **No Insurance**

Health Insurance: _____ Phone: (____) _____ Group No _____

In case of injury or sickness, I give permission for my child, _____, to have emergency medical or dental treatment, including transportation to a medical facility. I also assume 100% responsibility for payment of any such treatment.

Do any of the students or family members participating in Gym Magic's activities have physical or mental limitations requiring special consideration? ____ Yes ____ No --- If YES (which child), please explain _____

Parent or Legal Guardian's Signature _____ Date: ____/____/____

Audio and Image Consent

By attending camps, I am granting my permission for me and my child to be filmed, audio taped or photographed by any means and are granting full use of our likeness, voice, and words without compensation.

Parent or Legal Guardian's Signature _____ Date: ____/____/____