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Camp Crossway Registration Form:

Your child must have current immunization records prior to registration

Camper information

DOB _____ Age _____ Rising Grade _____ Male ___ Female ___
Last Name _____ First Name _____ Called _____
Address _____
City _____ State _____ Zip _____
Phone Number _____ Family E-mail _____

Mother/Guardian _____ Father/Guardian _____
Address _____ Address _____

City _____ City _____
Mother/Guardian Home # _____ Father/Guardian Home # _____
Mother/Guardian Cell # _____ Father/Guardian Cell # _____
Mother/Guardian Work # _____ Father/Guardian Work # _____

Medical History

Allergies: _____
Medications: _____
Insurance information: Name of Carrier: _____
Group Policy: _____ Name of Insured: _____

Immunizations: Please mark if current and provide documentation of the record: _____

Date of last tetanus shot _____
Description of camp activities from which camper should be exempted from for health reasons _____

Description of current physical, mental or psychological conditions requiring medication, treatment or special considerations while at camp _____

Record of past medical treatment, operations or serious injury _____

Child's Physician _____ Phone # _____

Date of Last Exam _____

Emergency Contacts

Name _____ Phone # _____ Relationship to Camper _____

Name _____ Phone # _____ Relationship to Camper _____

Waiver

This health history is complete and accurate to the best of my knowledge. I understand that Crossway Pediatric Therapy assumes no responsibility for injuries or illnesses which may result from his/her participation in the summer camp classes and activities. I agree to hold harmless the staff and volunteers of Crossway Pediatric Therapy for accidents or injuries arising out of the campers participation in the activities. Crossway Pediatric Therapy adheres to OSHA standards, ADA and HIPAA guidelines. If my child requires special accommodations, I understand that I must contact Shelley Portaro, director to request the accommodations.

Registration dates:

Summer Camp: registration and deposit of \$125 due by June 1 and the remainder by June 15. Deposits will be refunded if participant numbers are not met. Past due balances will result in the forfeiture of the camper's slot.

Tax Information and Receipts: Tax ID# 32-0095955. Please make checks payable to Crossway Pediatric Therapy. We also accept MasterCard and Visa. Please contact Shelley Portaro for receipts.

Prompt Pick Up: Unless an emergency situation arises, there will be a \$5 per 5 minutes late fee for children that are not picked up by the close of the camp.

I HAVE READ AND AGREE TO ALL THE POLICIES SET FORTH BY CROSSWAY PEDIATRIC THERAPY SUMMER CAMP AND CLASS PROGRAM.

SIGNATURE _____ DATE _____