





**Parent/Guardian Information:** Please provide the following information about your family:

Marital Status:  Married  Separated  Divorced  Single  Widowed

Child lives with:  Both Parents  Mother  Father

Mother's name: \_\_\_\_\_

Address: (Home Address – if same, write "same"): \_\_\_\_\_

1<sup>st</sup> # to call \_\_\_\_\_ / \_\_\_\_\_ - \_\_\_\_\_ D.L. No. \_\_\_\_\_

2<sup>nd</sup> # to call \_\_\_\_\_ / \_\_\_\_\_ - \_\_\_\_\_

E-mail \_\_\_\_\_ @ \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Father's Name: \_\_\_\_\_

Address: (Home Address – if same, write "same") \_\_\_\_\_

1<sup>st</sup> # to call \_\_\_\_\_ / \_\_\_\_\_ - \_\_\_\_\_ D.L. No. \_\_\_\_\_

2<sup>nd</sup> # to call \_\_\_\_\_ / \_\_\_\_\_ - \_\_\_\_\_

E-mail \_\_\_\_\_ @ \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

**Emergency Contact (other than parent):**

Name: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

phone number \_\_\_\_\_ / \_\_\_\_\_ - \_\_\_\_\_

**Other Contacts**

Name	Relation to Child	Phone Number(s)
_____	_____	_____
_____	_____	_____



**Additional information (medical needs and other individual considerations):**

- Dietary Restrictions: Please write any/all food allergies, sensitivities and restrictions:

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- Medications and medical conditions: (If your child has medications that will be administered during the day, please request and complete the *Medication Dosage Schedule* form.)

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- Limitations on activity: Please indicate any activities that your child cannot participate in for physical, cultural or other reasons:

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Liability Release/Hold Harmless Agreement:

I have read and understand the descriptions of summer camp activities, I hereby release and agree to hold harmless ArborCreek Montessori Academy Inc. and its officials, agents and employees from any claims arising out of my child's participation in summer camp, including but not limited to: accident, injury, loss of property, or damages. I also understand that in the event of emergency or medical need, I have given my permission for my child to receive medical treatment by the best means available.

\_\_\_\_\_  
(Parent or Guardian Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Parent or Guardian Printed Name)