



Girassol Learning Center Summer Camp

2024

Please print.

Date _____

Child's Information

Name _____ Preferred name _____
 First *Middle* *Last*

Date of Birth _____ (MM/DD/YYYY)

Please provide the weeks you want your child to attend: Example: Week of May 20 – 24.

During the weeks you listed, please circle the days of the week you are interested in for your child.

Monday Tuesday Wednesday Thursday Friday

Parent/Guardian Information

Please provide information for the parent(s) or legal guardian(s) with whom the child lives.

Name _____ Relationship to child _____

Address _____ E-mail _____

Home phone _____ Work phone _____ Cell phone _____

Emergency Contact Information

Please provide the name of a contact not living in the child's home.

Name _____ Relationship _____ Phone _____

Child's Physician

Name _____ Phone _____

Acknowledgement

By signing below, I/we grant permission for the child named above to participate in all activities connected with this Girassol Escola de Artes program/class. I/we further agree to abide by all policies that are applicable to this program.

Parent/Guardian Signature _____ Date _____

Administrator Signature _____ Date _____