



# Yoga Summer Camp 2019

Child's First Name	Child's Last Name	Grade in September
Preferred Name	Date of Birth MM DD YYYY	Age
Home Address		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
City	Primary Telephone	
State	Postal Code	

PARENT/GUARDIAN INFORMATION		
Parent's First Name	Parent's Last Name	Primary Phone <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Pager <input type="checkbox"/> Home
Home Address - Street/City/Postal Code (if different from child)		Alt. Phone #1 <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Pager <input type="checkbox"/> Home
Work Address - Street/City/Postal Code		Alt. Phone #2 <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Pager <input type="checkbox"/> Home
Parent's Email Address		

Parent's First Name	Parent's Last Name	Primary Phone <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Pager <input type="checkbox"/> Home
Home Address - Street/City/Postal Code (if different from child)		Alt. Phone #1 <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Pager <input type="checkbox"/> Home
Work Address - Street/City/Postal Code		Alt. Phone #2 <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Pager <input type="checkbox"/> Home
Parent's Email Address		

HEALTH & MEDICAL INFORMATION		
Family Doctor	Telephone	
Address	City	Postal Code

Please indicate if child experiences or has experienced any of the following:

Problem	Yes	No	Unknown	Details
Seizures				
Vision/Hearing Difficulties				
Mobility Difficulties				
ADHD				
Asthma				
Diabetes				
Any Other Personal Challenges				
Allergies:	<input type="checkbox"/> Nuts <input type="checkbox"/> Bee Stings <input type="checkbox"/> Food <input type="checkbox"/> Latex <input type="checkbox"/> Medication <input type="checkbox"/> Other (please specify)		Epi Pen Required? <input type="checkbox"/> Yes <input type="checkbox"/> No Dietary Restrictions?	