

Your Information

Circle of Friends
 40 King Street Norwalk, CT 06851
 203-293-8837 - Fax: 203-831-8969
 circlefriendsct@gmail.com
 www.circleoffriendsct.org

Full Name _____

Hebrew Name (If applicable) _____

Birthday ____/____/____ AM PM Age _____

Address _____

City _____ Zip Code _____

Home Phone _____

Cell Phone _____

Email _____

School _____ Grade _____

Camp Counselor Registration Form

I understand that I am making a commitment to be a counselor and a child is being accepted in camp based on my commitment.

In the event I will be unable to attend I will make sure to find a replacement.

CAMP DATES

Mon. Dec. 26- Thursday Dec. 29
9:15 AM -2:45 PM

Thank you for making this commitment and allowing a child with special needs enjoy a week of camp!

Parental Consent & Medical Information

Father's name _____ Work Phone _____ Cell Phone _____ Email _____

Mother's name _____ Work Phone _____ Cell Phone _____ Email _____

My child has permission to participate in all activities planned by Circle of Friends (unless stated below). I agree not to hold Circle of Friends liable for any accident, loss or theft that may occur during any events.

Restrictions: _____

In case of an emergency, when neither parent can be reached, person who will take responsibility for your child.

Name: _____ Phone (Home) _____ (Cell) _____

Address: _____ City: _____ Relationship to volunteer _____

Health insurance: Name: _____ Number: _____

Allergies to medication/food _____

Any special medical circumstances _____

Will your child need to take medications during camp hours? _____

If Yes to above questions, please fill out an allergy/health alert sheet, medication permission form.

I give my child permission to volunteer in the Circle of Friends Camp. Yes No

I permit my child's photos/video to be used for publicity purposes. Yes No

In case of medical emergency, (G-d forbid) the Circle of Friends will call 911. If it warrants swift medical attention, your child will be taken to the nearest hospital together with his/her medical file. Parents will be immediately notified. Until a parent is reached, the director or head counselor will be in charge and make all decisions about the care of the counselor. In all non-emergency situations, the parents will be contacted. If parents cannot be reached, we will contact your Doctor and follow their instructions. In situations where the volunteer must be taken home and you cannot be reached, we will contact the people you indicated above; By signing this form you also consent to assume any and all fiscal responsibilities incurred by the Circle of Friends I in the course of your child's medical emergency.

I hereby authorize Circle of Friends to obtain necessary medical treatment form my child in accordance with the above mentioned Emergency Policy.

I agree to the terms and conditions of this application.

Signature of Parent / Guardian _____ Date _____ / _____ / _____