



TIME FOR TEENS APPLICATION
August 1st-4th 2016

Child's Name _____

Mailing Address _____

Age _____ Date of Birth _____ [] Male [] Female

Upcoming School Year _____ School Attending _____ Grade _____

Mother/Guardian _____

Address (if different) _____

Contact Information - Home Phone _____ Work _____ Cell _____

E-mail _____

Father/Guardian _____

Address (if different) _____

Contact Information - Home Phone _____ Work _____ Cell _____

E-mail _____

RECREATIONAL INTERESTS

Swimming Arts & Crafts Soccer Basketball Kickball

Volley Ball Board Games Drama Story Telling Nature Hikes

Other (please explain) _____

HEALTH HISTORY

Does this child have any health problems? _____

Any dietary restrictions? _____ Allergies? _____

Are all of your child's immunizations up-to-date? _____

If there are medications that may need to be administered to your child during camp, please fill out the Medication Profile below and bring to Camp in original packaging.

MEDICATION PROFILE

Name of medication to be administered: _____ Dosage: _____

Time to be administered: _____ Physician's Name: _____ Phone # _____

I give permission to the Time For Teens Staff to administer prescriptions named above, if applicable, and/or first aid to my child.

IN CASE OF EMERGENCY, CONTACT _____ Phone # _____

Signature _____ Date _____

T-SHIRT SIZE Children S M L

Adult S M L