



CAMPERS LAST NAME

FIRST INITIAL

PARENT / GUARDIAN SIGNATURE

Location: New Life Lutheran Church  
8010 Fruitville Rd, Sarasota, 34240

## LIFE SKILLS PREP CAMP - REGISTRATION FORM

**Please print clearly. Please complete one (1) form per person.** Please complete all the blanks on this form. If there is a blank that is not applicable, please write 'n/a' in that blank. ~~Incomplete forms cannot be accepted~~ and we will be unable to provide care until all paperwork has been completed and submitted. If you have any questions about completing this form, please contact Lori Stephens at (941) 345-7574. **This form must be completed, signed by a parent or guardian** and returned to: Lori Stephens at lori@loristephensllc.com or mailed to Life Skills Prep Camp 40 Sarasota Center Blvd., #101 Sarasota, FL. 34240

**Circle Session Wanted      June      July**

### CHILD'S INFORMATION

CHILD'S FULL NAME			NICKNAME	
ADDRESS				
CITY		STATE	ZIP	
SCHOOL	CURRENT GRADE	AGE	DATE OF BIRTH	
OTHER SCHOOLS / PROGRAMS CONCURRENTLY ATTENDING			GENDER	

### PARENT/GUARDIAN AND MEDICAL INFORMATION - PLEASE INDICATE ORDER OF PRIORITY (1-4), WHICH PHONE TO CONTACT

PARENT / GUARDIANS NAME		DATE OF BIRTH	CELLPHONE	PRIORITY
ADDRESS				
CITY	STATE	ZIP	EMAIL	
PLACE OF EMPLOYMENT			WORK PHONE	PRIORITY
PARENT / GUARDIANS NAME		DATE OF BIRTH	CELLPHONE	PRIORITY
ADDRESS				
CITY	STATE	ZIP	EMAIL	
PLACE OF EMPLOYMENT			WORK PHONE	PRIORITY
DOCTOR'S NAME			DOCTOR'S PHONE	
MEDICAL INSURANCE PROVIDER			POLICY #	

### EMERGENCY CONTACTS - CONTACT INFORMATION OF 2 PEOPLE TO BE REACHED IN THE EVENT NEITHER PARENT/GUARDIAN CAN BE REACHED

EMERGENCY CONTACT NAME			CELLPHONE / HOME PHONE	
ADDRESS				
CITY	STATE	ZIP	WORK PHONE	
EMERGENCY CONTACT NAME			CELLPHONE / HOME PHONE	
ADDRESS				
CITY	STATE	ZIP	WORK PHONE	

### ADDITIONAL INFORMATION - ATTACH ADDITIONAL SHEETS IF EXTRA SPACE IS NEEDED.

AUTHORIZED PERSON FOR PICK-UP (IN ADDITION TO PARENTS AND EMERGENCY CONTACTS)
PERSON(S) NOT AUTHORIZED FOR PICK-UP (APPROPRIATE LEGAL PAPERWORK MUST BE ON FILE WHEN THE CUSTODIAL PARENT REQUESTS NOT TO RELEASE THE CHILD TO THE OTHER PARENT)
PREVIOUS SCHOOL AND CHILD CARE CENTERS ATTENDED
DOES YOUR CHILD HAVE ANY ALLERGIES AND/OR INTOLERANCES TO FOOD, MEDICATION OR ANY OTHER SUBSTANCES? WHAT ARE THE SYMPTOMS AND ACTION TO BE TAKEN, IF ANY?
PLEASE PROVIDE INFORMATION ON ANY CHRONIC PHYSICAL PROBLEMS AND PERTINENT DEVELOPMENTAL INFORMATION AND ANY SPECIAL ACCOMODATIONS NEEDED. (INCLUDING, BUT NOT LIMITED TO ANGER MANAGEMENT ISSUES, SENSORY INTEGRATION ISSUES OR OTHER POTENTIAL TRIGGERS OUR STAFF SHOULD BE AWARE OF.)
<input type="checkbox"/> CHECK HERE IF YOUR CHILD WILL BE REQUIRED TO TAKE ANY MEDICATION(S) DURING CAMP HOURS AND COMPLETE MEDICATION AUTHORIZATION FORMS