Busy Bee Summer Camp - 2017 REGISTRATION FORM

Name: _____
(Please print first and last)

Home Phone Number: _____ Home Address: _____

Mothers Name: _____ Fathers Name: _____
(First and last) (First and last)

Mothers Work Phone Number: _____ Cell Number: _____
(Required) (Required)

Fathers Work Phone Number: _____ Cell Number: _____
(Required) (Required)

EMAIL ADDRESS: _____ EMAIL ADDRESS: _____

Please circle grade for fall of 2017: 1 2 3 4 5 6

Students in grades 1 through 6 will be grouped according to age. Ratios in each program will be 1 adult to 18 children.

Tuition: (paid weekly) $ 25.00 ½ DAY
$ 40.00 FULL DAY PER CHILD
$ 185.00 FULL WEEK FIRST CHILD
FAMILY DISCOUNT FOR MULTIPLE CHILDREN (FULL WEEK ONLY) (See Peggy McConnell)

Please check the week and/or days you wish to enroll your child in:

	Entire Week	Monday AM PM	Tuesday AM PM	Wednesday AM PM	Thursday AM PM	Friday AM PM
June 19-23 Safety Week	_____	___ ___	___ ___	___ ___	___ ___	___ ___
June 26-30 Animal Week	_____	___ ___	___ ___	___ ___	___ ___	___ ___
July 5-7 Rainforest Week	_____	Closed	Closed	___ ___	___ ___	___ ___
July 10-14 International Week	_____	___ ___	___ ___	___ ___	___ ___	___ ___
July17-21 Medieval Week	_____	___ ___	___ ___	___ ___	___ ___	___ ___
July 24-28 Game Week	_____	___ ___	___ ___	___ ___	___ ___	___ ___
July 31-Aug 4 Island Week	_____	___ ___	___ ___	___ ___	___ ___	___ ___
August 7-11 Pirate Week	_____	___ ___	___ ___	___ ___	___ ___	___ ___
August 14-18 Who's got talent?	_____	___ ___	___ ___	___ ___	___ ___	___ ___
August 21-25 Dr. Seuss Week	_____	___ ___	___ ___	___ ___	___ ___	___ ___

We are closed July 3&4 full time campers will be charged $40.00 per day

$40.00 Registration Fee Paid: Date_____ Received by: _____

Check one: Cash _____ Check _____ # _____ Pay schools _____

CHILD INFORMATION RECORD

State of Michigan Department of Human Services - Bureau of Children and Adult Licensing

Instructions: Unless otherwise indicated, all requested information must be provided. If the information is not known or does not apply, "unknown" or "none" is the required response. A blank field, a line through a field or "N/A" are not acceptable responses.

For Provider Use Only:	Date of Admission	Date of Discharge

Name of Child (Last, First, Middle Initial)				Child's Date of Birth
Address (Number and Street, Building/Apartment Number)		City	State	Zip Code

Father/Legal Guardian's Name		Home Phone ( )	Mother/Legal Guardian's Name		Home Phone ( )
Home Address (if not child's address)		Cell Phone ( )	Home Address (if not child's address)		Cell Phone ( )
City	State	Zip Code	City	State	Zip Code
Email Address (optional)			Email Address (optional)		
Employer Name		Work Phone ( )	Employer Name		Work Phone ( )

Name of Child's Physician or Health Clinic	Physician's or Health Clinic's Phone Number ( )
Hospital Preferred for Emergency Treatment (optional)	
Allergies, Special Needs and Special Instructions (Attach additional sheets, if necessary.)	

BCAL-3731 (Rev. 7-12) Previous editions 9-09, 3-08, 10-07, & 1-06 may be used until 12/31/13. **See Reverse Side**

Emergency Contact & Release of Child: List all individuals,including parents/legal guardians, in order of preference, to be contacted in an emergency. If possible, include at least one person other than the parents/legal guardians to be contacted in an emergency and to whom the child can be released. The second phone number column can be left blank. (If more individuals, attach additional sheets.)

1.	( )	( )
2.	( )	( )
3.	( )	( )

Release of Child Only: List all individuals, other than the parents/legal guardians, to whom the child may be released. (If more individuals, attach additional sheets.)

1.	( )	2.	( )
3.	( )	4.	( )

I give permission to _____ , licensed by the Department of Human Services
(Provider's Name)

to secure emergency medical and/or emergency surgical treatment for the above named minor child while in care.

Signature of Parent or Guardian	Date Signed

Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

AUTHORITY: 1973 PA 116
COMPLETION: Required
PENALTY: Rule Violation Citation.

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Busy Bee Program – Medical Questionnaire

Child's Name: _____ Teacher: _____

Please check any of the following problems that may require the special attention of our staff:

Allergies or reactions (i.e., food, medications, etc.)	_____ Yes	_____No
Hay fever, asthma or wheezing	_____ Yes	_____No
Sleeping problems	_____ Yes	_____No
Eczema or frequent skin rashes	_____ Yes	_____No
Convulsion/Seizures	_____ Yes	_____No
Emotional problems	_____ Yes	_____No
Physical limitations	_____ Yes	_____No
Heart trouble	_____ Yes	_____No
Diabetes	_____ Yes	_____No
Frequent colds, sore throats, ear infections	_____ Yes	_____No
Trouble with passing urine or bowel movements	_____ Yes	_____No
Shortness of breath	_____ Yes	_____No
Speech problems	_____ Yes	_____No
Dental problems	_____ Yes	_____No

If you checked "Yes" to any of the above; is there a plan for this condition on file in the school office? ___Yes ___ No

Chicken Pox: Please check the following which applies.
_____ My child has had Chicken Pox
_____ My child was vaccinated against Chicken Pox
_____I have completed a waiver for the vaccination of Chicken Pox

Are your child's immunizations up to date? _____ Date of last Tetanus shot _____

Does your child take medication regularly? _____ Yes _____No
If yes, list medication _____Reason for medication _____

Is there any condition (vision, hearing or other) for which we could help by seating or other action?
_____ Yes _____No If yes, please explain _____

Should your child's activity be restricted because of any physical defect of illness?
_____ Yes _____No If yes, please check and explain degree of restriction.
_____Classroom _____ Playground _____ Gym Explain _____

I certify that my child is in good health. _____ Yes _____No If no, please explain
_____

Parent/Guardian Signature: _____ Date: _____