

GATEWAY MIDDLE SCHOOL AFTER-SCHOOL PROGRAM

Summer Camp Registration Form

Student Name: _____ Student's grade next year: _____

Address: _____ City: _____ Zip: _____

Days you are registering for: Monday & Wednesday _____ **OR** Tuesday & Thursday _____

Workshop your child would like to participate in: Dance, Art, or Outdoor Exploration

First Choice: _____ Second Choice: _____

What time do you anticipate dropping off your child? (drop off is between 8:00 to 9:00) _____

What time do you anticipate picking up your child? (pick-up is between 3:00 to 4:00) _____

(This will help us to figure out staffing at drop off and pick up time)

Program Fees:

(Reminder: If we cannot raise the necessary amount through pre-paid fees we will not be able to run the camp)

_____ Enclosed is payment of 200.00 for the entire camp. (25.00 a day)

_____ Enclosed is payment of 100.00 for the first 2 weeks. (25.00 a day)

_____ Enclosed is payment of 70.00 for the first week of camp. (35.00 a day)

_____ I will need a partial scholarship. I can pay _____.

_____ I will need a full scholarship.

Please make checks out to HEC or Hampshire Educational Collaborative.

Please drop off registration form and fee to the middle school office or mail to:

Gateway Regional Middle School

Attention: Shannon Madden/After-School Program

12 Littleville Road, Huntington, MA 01050

Please sign:

I give my child _____ permission to go off school grounds for field trips.

Transportation to be provided by First Student.

Parent/guardian signature

Date

Emergency Contact Information: With whom does student live with? _____

1. Parent/Guardian Name: _____

Home Phone #: _____

Workplace: _____ Work Phone: _____

2. Parent/Guardian Name: _____

Home Phone #: _____

Workplace: _____ Work Phone: _____

Other people to contact in case of emergency:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Pick Up Policy:

Each child must be picked up by 4:00 p.m. each day. Please list any other adults that may pick up child.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Are there any persons that are **NOT** permitted to pick up your child? If yes,

Name: _____ Relationship to student: _____

MEDICAL INFORMATION

Student Name _____ Date of Birth _____

Medical Insurance _____

Medical Insurance Certificate# _____

Employer of Insurance Holder: _____

Student's Health Care Provider _____

Provider's Address _____ Phone _____

Is there anything you would like us to know about you child (learning style, strengths, challenges)? _____

List any health issues your child has _____

List any known allergies your child has _____

List medications that your child takes, including inhaler or Epi-pen. _____

Does your child need to take medication during program hours? Medication includes prescription as well as over the counter medications. Yes _____ No _____

Do you give permission for your child to take the medication during the program? _____

I/we grant permission to any member of the Hampshire Educational and Gateway Middle School Staff, who are part of the program, to authorize treatment by a doctor, hospital, or medical center to my child _____ in case of an emergency. The Hampshire Educational Collaborative will make every reasonable effort to first contact parent/guardian.

Parent/Guardian Print Name

Parent/Guardian Signature

Date