

APPLICATION
CUMBERLAND YOUTH FOUNDATION DAY PLAYERS CAMP
MAY 27TH – AUGUST 8TH, 2008
7:30 AM – 6:00 PM MONDAY THRU FRIDAY
1505 NORTH MOORE ROAD
CHATTANOOGA, TN 37411
PHONE (423) 698-2556 FAX (423) 629-6683
****YOUR \$150.00 DEPOSIT IS NON-REFUNDABLE****

FOR OFFICE USE ONLY:

DEPOSIT \$ _____
PAYMENT(S) _____
PAID IN FULL DATE _____
RECEIPT # _____

IF THIS IS YOUR CHILD'S FIRST YEAR ATTENDING CAMP, PLEASE BE SURE TO INCLUDE A COPY OF THE CHILD'S BIRTH CERTIFICATE.

CHILD'S FULL NAME: _____ AGE: _____

NAME CHILD GOES BY: _____ DOB: _____

T- SHIRT SIZE (CHECK ONE): YOUTH (XS) (S) (M) (L) (XL)
ADULT (S) (M) (L) (XL)

*Be sure you select your child's correct T-Shirt size as no replacement shirts will be issued. T-shirts will be ordered approximately 2 weeks after camp begins.

PARENT/GUARDIAN INFORMATION

MOTHER'S FULL NAME

FATHER'S FULL NAME

ADDRESS

ADDRESS

CITY STATE ZIP

CITY STATE ZIP

HOME PHONE NUMBER

HOME PHONE NUMBER

EMPLOYER

EMPLOYER

WORK OR CELL PHONE NUMBER

WORK OR CELL PHONE NUMBER

EMAIL ADDRESS

EMAIL ADDRESS

**PLEASE PUT THE EMAIL ADDRESS YOU CHECK MOST FREQUENTLY.

TRANSPORTATION PLAN: To insure the safety of your child, please list other adults to whom your child may be released or who are authorized to provide transportation for your child.

PHONE NUMBER

PHONE NUMBER (PLEASE TURN OVER)



EMERGENCY INFORMATION: (We do not have medical facilities but may need information in case of accident or illness.)

NAME OF PERSON AUTHORIZED TO ACT FOR PARENT IN AN EMERGENCY. (IF A PARENT CANNOT BE REACHED.)

NAME

PHONE NUMBER

ADDRESS

CITY

STATE

ZIP

In divorce situation, the parent with legal custody is:

NAME

DAYTIME PHONE NUMBER

OTHER CHILDREN IN FAMILY:

MEDICAL INFORMATION:

NAME OF PRIMARY CARE PHYSICIAN

OFFICE HOURS

ADDRESS

OFFICE PHONE NUMBER

CITY

STATE

ZIP

1. Is your child allergic to any medications?

If so, name:

2. Does your child have any food allergies and/or any other severe allergies?

3. Does your child take any medications on a regular basis? If so, please provide name and schedule.

4. Has your child had swimming lessons and how would you rate his/her skills?

5. Health Insurance Provider _____

Primary Insurance Holder _____ ID # _____

Group # _____

6. Please note any other medical or personal information you feel we should know about your child.

7. Is your child overly sensitive to the sun? ____ YES ____ NO

8. In case of a need for emergency treatment, which hospital do you prefer?
(If no hospital is noted, your child will be taken to Children's Hospital.)

ALL INFORMATION PROVIDED IS TRUE. THE CYF STAFF HAS PERMISSION TO SEEK MEDICAL ATTENTION FOR THE ABOVE MENTIONED MINOR IN CASE OF EMERGENCY.

PARENT/GUARDIAN SIGNATURE: _____ ***DATE:*** _____

COMMENTS OR ADDITIONAL INFORMATION:

****PLEASE NOTE: THERE WILL BE A MANDATORY PARENTS MEETING ON TUESDAY, MAY 20TH AT 6:00 PM IN THE FELLOWSHIP HALL. EVEN IF YOUR CHILD IS A VETERAN DAY PLAYER, YOU ARE HIGHLY ENCOURAGED TO ATTEND.**