

Camp Friendship: June 12-16 Elementary Rising 6th - AM \_\_

Camp Friendship: June 12-16 Young ages 4-7 - PM \_\_

Camp Friendship: June 19-23 Young Ages 4-7 - AM \_\_

Camp Friendship: June 19-23 Elementary Rising 6th - PM \_\_

**AM - 9:30 - 12:00**

**PM - 1:30 - 4:00**

**MAKE CHECK PAYABLE TO GAYLE BORN DATE: \_\_\_\_\_**  
**CAMP FRIENDSHIP 2023**

Parents' Names: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_

Grade in School: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Dad's Cell: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Mom's Cell: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Siblings: \_\_\_\_\_

Allergies: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Referred By: \_\_\_\_\_

Therapists currently working with your child: \_\_\_\_\_

Medications your child is currently taking and the dosage: \_\_\_\_\_

Goals for your child: \_\_\_\_\_

I, \_\_\_\_\_, give my permission for Gayle Born, Margaret Brito or Jim Trotti in the event of an emergency to consult with other professionals regarding my child, \_\_\_\_\_. I give permission for my child to be transported by ambulance to Children's Healthcare of Atlanta for treatment.

Signature of Parent: \_\_\_\_\_ Date: \_\_\_\_\_

**MAKE CHECK PAYABLE TO GAYLE BORN**

Deposit paid: \_\_\_\_\_ Check #: \_\_\_\_\_ Date: \_\_\_\_\_