

Camp Friendship

DATE: _____ Student's Age: _____

Week of: June 8th – 12th
June 8th – 12th

9:30-11:30 am _____
12 noon- 3 pm _____

Each Session: \$475
Each Session: \$475
All Day: \$950

Week of: June 15th – June 19th
June 15th – June 19th

9:30-11:30 am _____
12 noon- 3 pm _____

MAKE CHECK PAYABLE TO Margaret Brito and mail to: 3830 Fenway Crossing Marietta, GA 30062

Camp Friendship REGISTRATION

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 Margaret Brito 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 Margaret Brito and mail to: 3830 Fenway Crossing Marietta, GA 30062

Deposit paid: _____ Check #: _____ Date: _____