Alpine Academy of Rockford
Faith • Family • Future

5001 Forest View Ave. Rockford, IL (815) 227-8894 FAX (815) 227-8899
www.AlpineAcademyofRockford.com laaoffice@yahoo.com

CHRISTMAS CAMP REGISTRATION

Student's Name Last First	**Birth Date** Month/Day/Year	**Sex**	**Age**

Allergies (Food, drug, insect, other)

Medication (List ALL prescribed or taken on a regular basis)

Diagnosis of asthma? Child wakes during the night coughing?	Yes No Yes No	Indicate Severity	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No	
Birth Defects?	Yes No		Hospitalization? When? What for?	Yes No	
Developmental delay?	Yes No				
Blood disorders? Hemophilia, Sickle Cell, Other? Explain	Yes No		Surgery? (List all) When? What for?	Yes No	
Diabetes?	Yes No		Serious injury or illness?	Yes No	
Head injury / Concussion / Passed out?	Yes No		TB Skin test positive? (past or present)	Yes* No	* If yes, refer to local health department
Seizures? What are they like?	Yes No		TB Disease? (past or present)	Yes * No	
Heart problems/ Shortness of breath?	Yes No		Tobacco use (type, frequency)?	Yes No	
Heart Murmur?	Yes No		Alcohol/Drug Use?	Yes No	
Dizziness or chest pain with exercise?	Yes No		Family history of sudden death before age 50? (Cause?)	Yes No	
Eye /Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor_____; Other concerns (lazy eye, crossed eye, drooping lids, squinting)			Dental ☐ Braces ☐ Bridge ☐ Plate ☐ Other		
Ear / Hearing problems?	Yes No		Information may be shared with appropriate personnel for health and educational purposes. X Parent/Guardian Signature Date		
Bone / Joint problems / injury / scoliosis?	Yes No				

Please check the appropriate boxes pertaining to your student.

☐ADD/ADHD ☐Headaches ☐Stomach ☐Speech Problems ☐Nose Bleeds ☐Anxiety ☐Diabetes ☐Neurological

In consideration of Alpine Academy Christmas Camp program permitting my child to participate in all activities relating to the camp program, I assume responsibility for my child's participation and agree that Alpine Academy will not be held liable for any claims or demands of any nature whatsoever which may arise by or be in connection with my child. I further certify that I, the parent or guardian, consent to the performance of emergency treatment as deemed necessary by camper personnel or physicians as a result of injury while participating in camp activities. I understand that every attempt will be made to contact me prior to such treatment, but in the event that no contact is possible, I authorize the Alpine Academy camper personnel to act on my behalf. I further agree that if the physician and hospital of my choice is not available in an emergency, the school has my permission to send my child to the nearest available hospital.

Parent/Guardian Signature_____Date_____

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FAMILY INFORMATION FOR PRIMARY RESIDENCE

Primary Parent:		Spouse :	
Primary Parent: (Address, City, State, Zip)			
Relationship:		Relationship:	
Employer:		Employer:	
Home #:	Cell #:	Home #:	Cell #:
Work #:		Work #:	

FAMILY INFORMATION FOR SECONDARY RESIDENCE

Second Parent:		Spouse:	
Relationship:		Relationship:	
Second Parent: (Address, City, State, Zip)			
Employer:		Employer:	
Home #:	Cell #:	Home #:	Cell #:
Work #:		Work #:	

EMERGENCY CONTACTS

Two adults who will assume responsibility for your child if the parent/guardian cannot be reached

Name:	Relationship:
Phone #1:	Phone #2:
Name:	Relationship:
Phone #1:	Phone #2:

Physician:	Hospital:

CHRISTMAS CAMP ATTENDANCE

Please indicate which days your child will be attending camp.
$150.00 for 7 days or $35.00 per day for drop-in.
Registration fee $25.00 for non-Alpine Academy students

☐ Fri., Dec. 20, 2013	☐ Fri., Dec. 27, 2013	☐ Fri., Jan. 3, 2014
☐ Mon., Dec. 23, 2013	☐ Mon., Dec. 30, 2013	
☐ Thur., Dec. 26, 2013	☐ Thurs., Jan. 2, 2014	