

## REGISTRATION FORM

Use one form per camper. If you need additional forms, photocopy, or download form at [www.crissyfield.org](http://www.crissyfield.org). Fax completed form to (415) 561-7695, or e-mail to [cfcregistrationinfo@parksconservancy.org](mailto:cfcregistrationinfo@parksconservancy.org), or mail to:

**Crissy Field Center**  
**Attn: Crissy Field Center Camps**  
**P.O. Box 29410**  
**San Francisco, CA 94129-0410**

### GENERAL INFORMATION

Camper Name \_\_\_\_\_ Gender: M F  
Birthdate \_\_\_\_\_ Age (when child starts camp) \_\_\_\_\_ Grade in fall 2009 \_\_\_\_\_  
School Name \_\_\_\_\_  
Parent/Guardian Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ Zip Code \_\_\_\_\_  
Preferred Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_  
E-mail Address \_\_\_\_\_  
T-shirt Size (circle): Youth XS S M L Adult S M L XL 2XL  
How did you hear about Crissy Field Center Camps? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### CRISSY FIELD CENTER CAMP REGISTRATION

SESSION NUMBER	SESSION DATES	CAMP NAME	FEE

Donation to Crissy Field Center Camps Scholarship Fund \_\_\_\_\_

**TOTAL \$** \_\_\_\_\_

### PAYMENT

Check/Money Order (payable to Crissy Field Center)

Credit Card:  MasterCard  Visa

Cardholder Name (as it appears on card) \_\_\_\_\_  
\_\_\_\_\_

Card Number \_\_\_\_\_ Exp. Date \_\_\_\_\_

### MEDICAL INFORMATION

Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Physician/Health Care Facility \_\_\_\_\_ Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Insured's Name \_\_\_\_\_ Policy No. \_\_\_\_\_

Check if applicable; list duration, treatment method, and/or restrictions.

#### Conditions

- Diabetes  
 Asthma  
 Heart trouble  
 Bleeding/clotting disorders  
 Other \_\_\_\_\_

#### Explanation:

#### Allergies Description & Reaction:

- Bee stings  
 Medications  
 Food or drink  
 Other \_\_\_\_\_

Date of last tetanus booster \_\_\_\_\_

Date of last TB shot \_\_\_\_\_

Medication (over-the-counter and/or prescription):  
\_\_\_\_\_  
\_\_\_\_\_

Emotional, behavioral, or learning disabilities:  
\_\_\_\_\_  
\_\_\_\_\_

If your child is under the care of a social worker, psychologist, behavior therapist, etc., please explain.  
\_\_\_\_\_  
\_\_\_\_\_

If a parent or guardian cannot be reached and the situation warrants it, initial by each medication that you authorize a trained Center staff member to give your child:

\_\_\_\_ Antihistamine (e.g., Liquid Benadryl) \_\_\_\_ Antibiotic ointment (e.g., Neosporin)

\_\_\_\_ Snake bite \_\_\_\_ Anti-diarrheal (e.g., Immodium AD) \_\_\_\_ Calamine or Tech-Nu

\_\_\_\_ Over-the-counter analgesic (e.g., Ibuprofen, Acetaminophen)

### EMERGENCY CONTACT/PICK-UP AUTHORIZATION

(include your name and spouse/partner name)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Hm Phone \_\_\_\_\_ Wk Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Hm Phone \_\_\_\_\_ Wk Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Hm Phone \_\_\_\_\_ Wk Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_