HAMPTON ACADEMY'S SUMMER PROGRAM APPLICATION

June 24th- August 16th, 2024

STUDENT INFORMATION		
Name:		
Date of birth:	Grade Completed:	Phone:
Current Address:		
Choose (Circle Below) SUMMER CAMP SUMMER SCHOOL THERAPY CAMP		Gender:
GUARDIAN INFORMATION		
Name:		
Employer Name:		Relationship:
City:	Email:	
Work Phone:	Cell Phone:	Home Phone:
Special Instructions:		
Emergency Contact		
Name:		
Address		Relationship:
Work Phone:	Cell Phone:	Home Phone:
Special Instructions:		
MEDICAL INFORMATION		
Physician's Name:		
Physician's Number:		
ADDITIONAL INFORMATION		
Does your child suffer from any medical condition that could affect his/her participation? YES NO (please circle)		
Does your child take medication for any illness? YES NO (please circle)		
Is your child ALLERGIC to anything?		
If enrolling in OFF SITE Activities- Can your child swim? YES NO If YES how well can he/she swim (0= not well at all 5= very well)		
SIGNATURES		
I, ________________________________ (print name) am enrolling the above named in Hampton Academy's Summer Program.		
Signature of applicant:		Date:
PLEASE NOTE: Children should be collected on time. Hours: 9am-3pm. Early Morning Care is available from 7:45am-9am ($20/weekly or $5/daily). Monday-Fridays. Hampton is CLOSED on Public Holidays.		

Registration: ____________ Summer Rate: ____________ Date Registered: ____________