



ICAC March Break Camp
Registration Form

Child's Name: _____	Age: _____
Birthdate: _____	
Address: _____	Postal Code: _____

Parent's Name(s): _____	
Home Phone: _____	Cell Phone: _____
Work No.: _____	Email Address: _____

In the case the parent(s) caregiver cannot be reached, we should contact:

Name	Relationship	Number

Please list ALL people authorized to sign your child in and out of day camp.

Name	Phone Number

Registration Date

Dates	Cost
March 11-March 15, 2024	\$200.00

Photo Permission:

I give ICAC permission to take photos/videos of my child for social media and promotional purposes. Please be advised that children will not be named or tagged in photos/videos.

Yes: _____ or No: _____



Medical Forms

Medical: Please list any medical conditions we should be made aware of (ie. usage of an Epi-pen*, allergies, ADHD, ADD, physical disabilities, emotional problems, learning disabilities or anything special we should know about your child. If your child has an allergy, please list signs, symptoms, and treatment:

Will your child require medication during camp? Yes: _____ No: _____

If Yes, My child can take their medication as described below _____ Or I give permission for the ICAC Camp Staff to administer their medication as described below _____

Medication	Expiry	Dose	Time	Signature

Medication (including Epi-pens) must be submitted to our office in its original prescribed bottle with your child's name on it. The medication administration chart above must match the prescription label.

Waiver (Please read carefully):

I permit my child to participate in all activities offered in the program. In the event of an accident or illness affecting my child, I consent to having the Ingersoll Creative Arts Centre Staff authorize any necessary procedures, including admission to hospital, as may deem essential for the care and wellbeing of the participant. Such action is to be taken only when immediate contact with the parent/guardian or emergency contact cannot be made. I understand that in order to be eligible for a refund that 2 weeks notice will be required to cancel care. If my child presents any symptoms of COVID 19, we will be following Public Health Guidelines. If a child is sick, or has symptoms that are aligned with COVID 19 and asked to leave, I understand that I will not receive a refund for the remainder of the Program.

I have read, understand, and accept the Ingersoll Creative Arts Summer Program's policies as described in this waiver and I have read and understand all information in the provided info packet.

Signature of Parent/Guardian: _____ Date: _____