

**Name of Child 3:** \_\_\_\_\_ **Preferred Name:** \_\_\_\_\_

**Gender:** Male / Female **Tshirt size:** \_\_\_\_\_

**Age:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_ **Grade Completed (as of June 30):** \_\_\_\_\_

Does your child have any **severe** allergies? Yes \_\_\_ No \_\_\_ **Life-threatening** allergies? Yes \_\_\_ No \_\_\_  
(ex. bee stings, food, penicillin, other medication) **Food** allergies? Yes \_\_\_ No \_\_\_

If yes, explain: \_\_\_\_\_

Is your child bringing any medication with him/her? (ex. antibiotics, inhaler, epipen) Yes \_\_\_ No \_\_\_

If yes, explain: \_\_\_\_\_

Does your child have any physical, emotional, mental or behavioral concerns or limitations that our staff should be aware of, which will help us to make your child comfortable and more effectively teach him/her? (For example, learning disabilities ....) Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, explain: \_\_\_\_\_

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**Name of Child 4:** \_\_\_\_\_ **Preferred Name:** \_\_\_\_\_

**Gender:** Male / Female **Tshirt size:** \_\_\_\_\_

**Age:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_ **Grade Completed (as of June 30):** \_\_\_\_\_

Does your child have any **severe** allergies? Yes \_\_\_ No \_\_\_ **Life-threatening** allergies? Yes \_\_\_ No \_\_\_  
(ex. bee stings, food, penicillin, other medication) **Food** allergies? Yes \_\_\_ No \_\_\_

If yes, explain: \_\_\_\_\_

Is your child bringing any medication with him/her? (ex. antibiotics, inhaler, epipen) Yes \_\_\_ No \_\_\_

If yes, explain: \_\_\_\_\_

Does your child have any physical, emotional, mental or behavioral concerns or limitations that our staff should be aware of, which will help us to make your child comfortable and more effectively teach him/her? (For example, learning disabilities ....) Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, explain: \_\_\_\_\_