



**Project Adventure**  
*Advancing Active Learning*

800.468.8898  
 www.pa.org

## SUMMER LEADERSHIP PROGRAM 2018 REGISTRATION FORM

This registration form and the Student Medical form must be completed in their entirety and returned to Project Adventure with a 50% deposit in order to confirm your child's space in our program. Please complete a different form for each child you are enrolling in this program. To optimize the challenge course experience and skill development at Project Adventure, **we recommend, but do not require, a minimum of two weeks enrollment per child.**

### **Please check your desired camp program(s):**

Regular day runs from 9:00am-3:00pm.

- Week #1: **July 23-27** (\$375)
- Week #2: **July 30- August 3** (\$375)
- Week #3: **August 6-10** (\$375)

Total Amount Due: \_\_\_\_\_ Amount Included Now (at least 50%): \_\_\_\_\_

Child's Full Name \_\_\_\_\_ Grade Completed June 2017: \_\_\_\_\_

Nickname, if applicable: \_\_\_\_\_ Age: \_\_\_\_\_ Male/Female \_\_\_\_\_

Address: \_\_\_\_\_

Mother/guardian full name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Father/guardian full name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Parent/guardian E-mail: \_\_\_\_\_

### ***If parents/guardians are unavailable:***

Emergency Contact Information (required):

Name : \_\_\_\_\_ Day time phone: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_ Evening phone: \_\_\_\_\_

**Persons authorized to pick up child other than parent/guardian (not required):**

Name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

( ) Returning Camp Participant ( ) New Camp Participant

How did you hear about our camp? \_\_\_\_\_

**Summer Adventure Camp  
Health and Medical Information Addendum**

*In addition to the information contained in the Student Medical form, the State of Massachusetts Department of Public Health requires that the following information be completed for any child attending this program.*

Please provide a photocopy of your child's **immunization records**, including the dates on which your child received each immunization. **Attach immunization records to this registration form.**

Date of Last Physical Exam: \_\_\_\_\_ (must be within 24 months of program end date)

Name, Phone number and Address of Child's Physician:

\_\_\_\_\_

List any/all medications to be administered during the program:

\_\_\_\_\_

*Please note that all medications must be given to the camp staff upon arrival, and must be in the original container with the original label clearly affixed. A permission to dispense medication form must also be completed upon dropping your child off at the program.*

Does your child have any dietary restrictions that we should be aware of?

\_\_\_\_\_

Does your child have social, emotional, or physical challenges that you would like us to be aware of?

\_\_\_\_\_

*Please return this registration form,  
PA Student Medical Form, and 50% deposit to:*

Youth & College Programs  
719 Cabot Street  
Beverly, MA 01915  
978-524-4558  
[info@pa.org](mailto:info@pa.org)