Summer Camp
Inclusive Educational Program
A Program By: DSAM & Brightsong

REGISTRATION FORM

Child's Name	Date of Birth	Male or Female
Name of Mother / Legal Guardian	**Home Phone**	**Cell Phone**
Home Address	**City, State, Zip**	
Work Phone	**E-Mail Address**	
Name of Father / Legal Guardian	**Home Phone**	**Cell Phone**
Home Address	**City, State, Zip**	
Work Phone	**E-Mail Address**	
Emergency Contact Person #1	**Phone Number & Relationship to Child**	
Emergency Contact Person #2	**Phone Number & Relationship to Child**	

FAMILY INFORMATION

Primary language spoken at home:
Religious background:

MEDICAL INFORMATION

Please list any documented allergies and reactions:
Does your child have an Epi-Pen? ☐ Yes ☐ No
Does your child have a history of swallowing issues? Please explain:
Has your child had a swallow study? ☐ Yes ☐ No
Results:
Treatment:
Have there been any serious illnesses, injuries or hospitalizations?
☐ Yes ☐ No Date(s):
Please explain:
Is your child currently receiving therapy services?
☐ Yes ☐ No If yes, please list the location and type of therapy:
Does your child have any behavioral concerns? Please describe:
How do you address these behaviors at home and school?
What goals would you like for us to focus on during Summer Steps?