

# GRANT COUNTY YOUTH SERVICE CENTER HOSTS

## CAMP BRAVES!

### REGISTRATION FORM

For Incoming Sixth Graders  
Wednesday, August 1, 2018  
8 a.m. – 12 p.m.  
Grant County Middle School

For Information, please contact:  
[Tyler.mullins@grant.kyschools.us](mailto:Tyler.mullins@grant.kyschools.us)  
[Kresta.hearn@grant.kyschools.us](mailto:Kresta.hearn@grant.kyschools.us)  
859-824-2347

[www.grant.kyschools.us](http://www.grant.kyschools.us)

Cost: \$10.00 (Early-bird registration through June 29, 2018)

\$15.00 (After June 29, 2018. Walk-ins welcome.)

Request scholarship if needed.

STUDENT NAME: [First, Middle, Last]		DATE OF BIRTH: [Click here to choose DOB.]	
GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female		ENTERING WHAT GRADE? [6, 7, or 8]	
ADDRESS: [Street Address]			
CITY: [City]		STATE: [State]	
PARENT PHONE NUMBER: [xxx-xxx-xxxx]		PARENT E-MAIL: [E-mail Address]	
ELEMENTARY SCHOOL ATTENDED: [School]			
My child, [Name], has permission to participate in Grant County Youth Service Center Camp Braves. <input type="checkbox"/> Yes <input type="checkbox"/> No			
I give permission for the GCYSC to publish pictures of my child participating in Camp Braves. <input type="checkbox"/> Yes <input type="checkbox"/> No			
PARENT / GUARDIAN SIGNATURE		DATE: [Select date.]	

#### STUDENT MEDICAL HISTORY

ALLERGIES: <input type="checkbox"/> None; <input type="checkbox"/> Hay Fever; <input type="checkbox"/> Insect Stings; <input type="checkbox"/> Poison Ivy/Poison Oak <input type="checkbox"/> Food [Click here to describe.]; <input type="checkbox"/> Drugs [Click here to describe.] <input type="checkbox"/> Other - Please describe. [Click here to describe.]	
CHRONIC OR RECURRING ILLNESS: <input type="checkbox"/> None; <input type="checkbox"/> Asthma; <input type="checkbox"/> Ear Infections; <input type="checkbox"/> Heart Disease; <input type="checkbox"/> Seizures; <input type="checkbox"/> Diabetes; <input type="checkbox"/> Behavior; <input type="checkbox"/> Other - Please describe. [Describe illness.]	
COMMENTS: [Click here to enter any information you would like us to know about your child.]	
MEDICATION: If your child will need medication during this period of time, the medication must be in its original container. It will be dispensed only under the specific direction of the ordering physician or under written instructions from parent/guardian. Please contact the School Nurse at 824-7161 or the Youth Service Center at 824-2346 prior to the event if medication will need to be administered.	
EMERGENCY TREATMENT: In case of emergency, when I cannot be reached, I give permission for my child to be treated by a qualified physician at the nearest hospital.	
PARENT SIGNATURE:	DATE: [Select today's date.]
EMERGENCY CONTACT: In case of emergency, I can be reached as follows:	
Name: [Parent/Guardian Name]	Phone: [Parent/Guardian Phone]
Address: [Address]	
Relationship to Participant: [Relationship]	
Physician's Name: [Physician's Name]	Physician's Phone: [Physician's Phone]