



**PROGRAM APPLICATION FORM**

Name of Program: \_\_\_\_\_

Program Code: \_\_\_\_\_

Program Date: \_\_\_\_\_

Registration Fee: \_\_\_\_\_

**PARTICIPANT INFORMATION:**

Name of Participant \_\_\_\_\_

Prefers to be called \_\_\_\_\_

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

City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_

Birth date \_\_\_\_\_ Age At Program \_\_\_\_\_

Female  Male

Parent \_\_\_\_\_

Parent \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_

Home (\_\_\_\_) \_\_\_\_\_

Home (\_\_\_\_) \_\_\_\_\_

Email \_\_\_\_\_

Email \_\_\_\_\_

Work (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Work (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

**Please provide the following information about your camper:**

Does your child have any known allergies? **Yes No** If yes, please list below:

Does your child carry an Epipen for any allergies? **Yes No** If yes, please explain:

Does your child receive any special services at school? **Yes No** If yes, please explain:

Is your child currently under a medical professional's care for any other physical or mental health conditions (excluding diabetes, asthma, heart condition) **Yes No** If yes, please explain:

Has your child been hospitalized within the past 24 months? **Yes No** If yes, please explain:

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

*Your child's registration will not be processed without your signature above.*

**REGISTRATION FEE PAYMENT:**

A non-refundable registration fee must accompany this registration form unless you have requested a waiver. Please make checks payable to: *Zebra Crossings*

Upon review of your application we will inform you of registration in the program. Specific program information, directions, what to bring, and contact information will be included in the registration.