The Pen Ryn School
Summer Program 2017

Child's Name _____ **Age** _____

Child's Name _____ **Age** _____

Address _____

_____

Mother's Name_____

Cell_____
Work_____
Home_____

Father's Name_____

Cell_____
Work_____
Home_____

Emergency Contacts:
First Contact Person _____ **Emergency Number** _____

Second Contact Person_____ **Emergency Number** _____

Please give any pertinent health history._____
_____
_____
_____

Allergic reactions (i.e., food, poison ivy, insect stings, penicillin, aspirin, etc.) Please give details and advise of emergency treatment required. (Please note: Teacher does not administer medications)_____
_____
_____
_____

In the event that your child needs hospital treatment, they will be taken to Aria Hospital Bucks Co.

WEEK 1 (6/19 - 6/23)

Program_____ Child_____

Program_____ Child_____

WEEK 2 (6/26 - 6/30)

Program_____ Child_____

Program_____Child_____

WEEK 3 (7/10 - 7/14)

Program_____Child_____

Program_____Child_____

WEEK 4 (7/17 - 7-21)

Program_____Child_____

Program_____Child_____

WEEK 5 (7/24 - 7/28)

Program _____Child_____

Program_____Child_____

Parent/Guardian Signature_____ Date_____

All Programs are $200 plus activity fee. Please make check out to The Pen Ryn School.

Before Camp Care($25) ***Yes*** ***No***

After Camp Care($25) ***Yes*** ***No***

Amout Paid _____ Check #_____