Rhode Island Department of Human Services

Summer Camp Registration Form

Updated 6/10/2020

Child Information			
Full Name:		Date of Birth:	
Primary Address			
Number & Street:			
City/Town:	State:	ZIP Code:	
List of Known Allergies (e.g., foods, medications, insects or other materials):			
List of Daily Medications, including dosage, time, and method of administration:			
Primary Care Physician			
Name:	Phone:		
City/Town:	State:	ZIP Code:	

Parent/Guardian Information				
Parent/Guardian's Full Legal Name:				
Primary Address			☐ Check if same as above	
Number & Street:				
City/Town:	State:	ZIP Code:		
Contact Information				
Primary Phone:		☐Mobile	☐Home	☐Work
Secondary Phone:		☐Mobile	☐Home	☐Work
Preferred Language:	☐English ☐Spanish ☐Other:_____			
Parent/Guardian's Full Legal Name:				
Primary Address			☐ Check if same as above	
Number & Street:				
City/Town:	State:	ZIP Code:		
Contact Information				
Primary Phone:		☐Mobile	☐Home	☐Work
Secondary Phone:		☐Mobile	☐Home	☐Work
Preferred Language:	☐English ☐Spanish ☐Other:_____			

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Authorized/Emergency Pick-Up Persons			
Full Name:		Relation to Child:	
Primary Phone:	☐Mobile ☐Home ☐Work		
Preferred Language:	☐English ☐Spanish ☐Other:_____		
Full Name:		Relation to Child:	
Primary Phone:	☐Mobile ☐Home ☐Work		
Preferred Language:	☐English ☐Spanish ☐Other:_____		
Full Name:		Relation to Child:	
Primary Phone:	☐Mobile ☐Home ☐Work		
Preferred Language:	☐English ☐Spanish ☐Other:_____		