



CAMP SCHOLARSHIP



50 ROLFE S QUARE CRANS TON, RI 02910 | PHONE 401.490.9475 FAX 401.490.9477 | WWW. ARTISTS-EXCHANG E.O RG

CAMPER NAME: _____ D.O.B _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Returning Camper NEW Camper How did you hear about us? _____

PARENT INFORMATION

Name: _____ Name: _____

Phone: _____ Phone: _____

Email: _____ Email: _____

MEDICAL INFORMATION

Please provide any pertinent medical information you feel is important for us to know including KNOWN ALLERGIES:

My child will be bringing a/n (circle one): Inhaler EpiPen * (Please have your child take any medications before/after camp)

AUTHORIZED PICK-UP INFORMATION

Your child will ONLY be released to the people on this list unless written permission is provided at morning drop off. All names must be listed exactly as they appear on driver's licenses. All individuals MUST SHOW A PHOTO I.D. EACH TIME THEY PICK UP YOUR CHILD. NO exceptions. THIS IS FOR YOUR CHILD'S SAFETY!

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

PHOTO AUTHORIZATION

Check here if you DO GIVE permission to use your child's image for promotional purposes.

Check here if you DO NOT GIVE permission.

REASON FOR SEAKING FINANCIAL ASSISTANCE

My child qualifies for free or reduced lunch. (circle one) Yes | No

FIRST CHOICE CAMP: _____

CAMPS TOTAL : \$ _____

SECOND CHOICE CAMP: _____

Donations: - \$ _____

THIRD CHOICE CAMP: _____

FINANCIAL ASSITANCE AWARDED : -\$ _____

EXTENDED CARE: 8am-9am 3 pm-4pm 4 pm-5pm

FINAL Total Due: \$ _____

\$8 x ___ day(s) M T W TH F = Daily Total: \$ _____

Payment Type _____ Payment Amount \$ _____

\$40 x ___ week(s) = Weekly Total: \$ _____

Date _____ Staff Initials _____ BALANCE \$ _____

Your signature verifies that all above information is current and correct.

Parent Signature _____

Date _____