Deaf Options, Inc.
Deaf Options Learning Center

Summer Program Registration
July 6, -July 31, 2009

## CHILD INFORMATION

Name:______________________________________________________________

Address:____________________________________________________________

City:________________________________________ Zip:__________________

Date of Birth:_____/______/___________ Grade:___________________________

School:_____________________________________________________________

## PARENT/GUARDIAN INFORMATION

Parent/Guardian:______________________________________________________

Address:____________________________________________________________

Home Phone:______________________ Work Phone:__________________________

Cell Phone:________________________Email:______________________________

Emergency Contact:

Name | Relationship to Child | Phone

1.__________________________________________________________________

2.__________________________________________________________________

## HEALTH INFORMATION

Is there any health concern we should be aware of?__________________________________

Please list all allergies:________________________________________________

Any foods your child will not eat?_________________________________________

***We will not administer medications. If you have concerns or questions, please contact Kathleen Mitchell.**

## PARENT/GUARDIAN RESPONSIBILITY/LIABILITY RELEASE

**Please pick up your child by 4:00 PM. Violation of this rule will terminate your child from the program.**

**Please list who can pick up your child other than the listed parent/guardian. We must have their names in the file before anyone other the parent can pick up your child.**

**1.________________________________2.____________________________**

**3.________________________________4.______________________________**

**Parent will provide child with a brown bag lunch labeled with child's name.**

The named applicant has my permission to attend and participate in the current year summer program sponsored by Deaf Options. This shall serve as my permission slip for daily excursions included with the program. I, _________________________________ will not hold the program liable for any circumstances or accidents occurring while my child is participating in this program.

Parent/Guardian signature Date

Program Staff Date

Send/Fax Form to:

Deaf Options, Inc.
ATTN: Kathleen Mitchell
19145 Beech Daly RD
Redford, MI 48240
313-279-0550 FAX