CATERPILLAR CLUBHOUSE
14201 Old Stage Road
Bowie, MD 20720
caterpillarclubhouseinc@gmail.com
www.mycaterpillarclubhouse.org

CCH SUMMER PROGRAM 2019

$50 Registration Fee to enroll and due with this application
(This fee is non-refundable and does not go towards your balance)

$195 per week (per child) - Please CHECK (√) the week(s) and number of children attending.
There is an additional $10 per day per family for extended hours which is from 5pm-6pm…

Week	Cost	√	# Children	Extended Hours	Total
6/17-6/21	$185				
6/24-6/28	$185				
7/1-7/5	$148				
7/8-7/12	$185				
7/15-7/19	$185				
7/22-7/26	$185				
7/29-8/2	$185				
8/5-8/9	$185				
TOTAL	$				

Child(ren)'s Name	DOB	AGE	GRADE 2019-20
1.			
2.			
3.			

Mother's Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

Email: _____ Cell Phone: _____

Father's Name: _____Home Phone: _____

Address: _____Work Phone: _____

Email: _____ Cell Phone: _____

Names of people in the area who can be contacted in emergencies:

1._____Day Phone: _____

2._____Day Phone: _____

3._____Day Phone: _____

Who is authorized to pick up your child? _____
_____

For Office Use Only
□Accepted □Waitlist □Withdrawn
Date Received_____

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Authorization for Child's Emergency Medical Treatment

If my child(ren) become(s) ill or involved in an accident and I cannot be reached, I authorize the following hospital or physician to give emergency medical treatment:

Hospital/Physician:_____

Address:_____

Phone:_____

I give the CATERPILLAR CLUBHOUSE permission to take my child for emergency medical treatment and/or to call for an ambulance. I understand that I am responsible for all charges and expenses incurred in the treatment of my child which is not covered by the following insurance:

Child's First Name	Health Insurance Company	Policy #	Coverage
1.			
2.			
3.			

Child's First Name	KNOWN ALLERGIES, DIETARY RESTRICTIONS, SPECIAL NEEDS AND/OR PHYSICAL CONDITIONS
1.	
2.	
3.	

IMMUNIZATION: The Department of Health now requires that we have a photocopy of your child(ren)'s recent immunization record in our files. Please include a photocopy with this registration form. If you do not have the records, a copy can be obtained from your child's pediatrician office.

PARENT SIGNATURE:_____ **DATE:**_____

PRINTED NAME: _____

PLEASE NOTE
It is the family's responsibility to keep all information on this form accurate, updated and relevant.
Thank You!

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