WONDERSPRING CAMP

Application Fee: Non-refundable $25 *(Waived for current families)*
Enrollment Fee: Non-refundable $50 *(Waived for current families)*
Deposit Per Session: Non-refundable $50 *(All families)*

Camp Wonderspring Pottstown - Application/Enrollment Form

School Child Attends:		Grade as of September 2020:	
Child's Name:	Gender:	Birth Date:	
Address Where Child Resides:	City:	State:	Zip:
Child Resides With: ☐ Both Parents ☐ Mother ☐ Father ☐ Other (Please Specify):		Primary Language Spoken at Home:	

Parent/Guardian 1 Information

Name:	Home Phone Number:	Cell Phone Number:	
Email Address:	Employer/Workplace:		
Work Address:		Work Phone Number:	
Home Address:	City:	State:	Zip:

Parent/Guardian 2 Information

Name:	Home Phone Number:	Cell Phone Number:	
Email Address:	Employer/Workplace:		
Work Address:		Work Phone Number:	
Home Address:	City:	State:	Zip:

Please check the camp session(s) needed. Each full time (FT) one-week session fee is $200.
Session fee includes a maximum 10 hours of care daily as well as all activities.

Session 1 (June 22nd to June 26th): ☐	Session 2 (June 29th to July 2nd, closed July 3rd): ☐
Session 3 (July 6th to July 10th): ☐	Session 4 (July 13th to July 17th): ☐
Session 5 (July 20th to July 24th): ☐	Session 6 (July 27th to July 31st): ☐
Session 7 (August 3rd to August 7th): ☐	Session 8 (August 10th to August 14th): ☐
Session 9 (August 17th to August 21st): ☐	

Please briefly describe any special needs, disabilities, or allergies of your child.

EMERGENCY CONTACT PERSON(S) Person(s) to whom child may be released other than the parents				
Name:	Home Phone Number:	Cell Phone Number:		
Address:	City:	State:	Zip:	Primary Language:
Name:	Home Phone Number:	Cell Phone Number:		
Address:	City:	State:	Zip:	Primary Language:
Name:	Home Phone Number:	Cell Phone Number:		
Address:	City:	State:	Zip:	Primary Language:

MEDICAL INFORMATION				
Name of child's Physician/Medical Care Provider:		Phone Number:		
Address:	City:	State:	Zip:	Primary Language:
Allergies (including medication reactions):				
Medical or Dietary Information Necessary in an Emergency Situation:				
Medication Special Conditions:				
Health Insurance Coverage for Child or Medical Assistance Benefits:				
Policy Number (required):	Date of Last Physical:			

PARENT'S SIGNATURE REQUIRED FOR EACH ITEM BELOW Indicates Consent	
Photos/Videos:	Admin of Minor First-Aid Procedures/Obtaining Medical Care:
Walks and Trips:	Transportation by the Facility:

Signature of Parent or Guardian: _____ Date: _____

Signature of Center Administrator: _____ Date: _____

PLEASE RETURN COMPLETED FORM TO ecorcoran@wonderspring.org or mail to 150 N. Hanover Street, Pottstown PA 19464