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 Wynnewood - 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 $250 (ELRC Families additional $30 + copay). Session fee includes a maximum 10 hours of care daily as well as all activities & field trips. Part-time care (9am-3pm) or 3 days a week are $180.

Session 1 (June 29th): ☐ FT ☐ PT: 9am-3pm || 3-Days Closed July 3rd	Session 2 (July 6th): ☐ FT ☐ PT: 9am-3pm || 3-Days
Session 3 (July 13th): ☐ FT ☐ PT: 9am-3pm || 3-Days	Session 4 (July 20th): ☐ FT ☐ PT: 9am-3pm || 3-Days
Session 5 (July 27th): ☐ FT ☐ PT: 9am-3pm || 3-Days	Session 6 (Aug 3rd): ☐ FT ☐ PT: 9am-3pm || 3-Days
Session 7 (Aug 10th): ☐ FT ☐ PT: 9am-3pm || 3-Days	Session 8 (Aug 17th): ☐ FT ☐ PT: 9am-3pm || 3-Days
Session 9 (Aug 24th): ☐ FT ☐ PT: 9am-3pm || 3-Days	Session 10 (Aug 31st): ☐ FT ☐ PT: 9am-3pm || 3-Days Last Day September 3rd

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 cmauro@wonderspring.org or mail to 230 Haverford Road, Wynnewood PA 19096*****