Wonder Of Learning Organization Child Care Centre
1346 Kingsway, Vancouver BC V5V 3E4
604-829-1346 | admin@wonderoflearning.ca | www.wonderoflearning.ca

STARTING DATE
_____/_____/_____
yy dd mm

BIRTHDATE
_____/_____/_____
yy dd mm

END DATE
_____/_____/_____
yy dd mm

CAMP PROGRAM REGISTRATION FORM

**Please fill out the information below and return. Please fill a different form for each sibling.*

GENERAL INFORMATION

First Name: _____ Last Name: _____ Age: _____
School (if applicable): _____ Current Grade: _____ Sibling(Names): _____
Parent's First Name (if applicable): _____ Parent's Last Name: _____
Address: _____ City: _____Postal Code: _____
Phone: _____ Cell: _____ Email: _____
Emergency Contact: _____Preferred method of contact: Phone / Cell / Email
How did you hear about us? _____
If it is a referral, please tell us who. _____

COMMENTS / INSTRUCTIONS

Hobbies or Interests: _____
Extra-curricular Activities: _____
Please tell us anything else you think will help us provide an enriching experience for your child:
_____
_____

HEALTH INFORMATION

Does your child have:* Allergies? ___YES** ___**NO** Asthma? ___**YES** ___**NO**
If yes, please provide further information:
_____
Has your child had a seizure in the past year? ___**YES** ___**NO**
If yes, please provide further information:
_____
Does your child require a special diet related to a medical condition? ___**YES** ___**NO**
If yes, please provide further information:
_____
Food sensitivities? ___**YES** ___**NO** If yes, please provide further information:
_____
A Medical condition/concern? ___**YES** ___**NO** If yes, please provide further information:
_____
List all prescription and "over the counter" medications your child receives:
Medication(s): _____ _____
Immunization documents returned to facility? ___**YES** ___**NO**
Does your child require extra support or extra help is desired? ___**YES** ___**NO**
If yes, please provide further information:
_____

Child's Name: _____ **Camp Week(s):** _____

HEALTH INFORMATION

Care Card / PHN #: _____

**Does your child have:*

Allergies? ___**YES** ___**NO** If yes, please provide further information:
_____

Asthma? ___**YES** ___**NO** If yes, please provide further information:
_____

Has your child had a seizure in the past year? ___**YES** ___**NO**
If yes, please provide further information:
_____

Does your child require a special diet related to a medical condition? ___**YES** ___**NO**
If yes, please provide further information:
_____

Food sensitivities? ___**YES** ___**NO** If yes, please provide further information:
_____

A Medical condition/concern? ___**YES** ___**NO** If yes, please provide further information:
_____

List all prescription and "over the counter" medications your child receives:
Medication(s): _____ _____
Immunization documents returned to facility? ___**YES** ___**NO**
Does your child require extra support or extra help is needed? ___**YES** ___**NO**
If yes, please provide further information:
_____

_____

_____

**You may be asked to complete additional forms if you answered yes to any of the above.*

Custody Agreement? _____YES _____N/A Provide to Facility? _____YES _____NO

INFORMATION PROVIDED BY:

_____	_____	_____
Date (yy/mm/dd)	*Print Name*	*Signature*

INFORMATION RECEIVED BY:

_____	_____	_____
Date (yy/mm/dd)	*Print Name*	*Signature*

2018-19 Child's Name: _____ **Camp Week(s):** _____

PHOTO & VIDEO RELEASE

I give permission for my child / for myself (*circle one*) to be photographed (including still, video and sound) as a participant in WOLO activities and consent to the reproduction, use, and distribution thereof for any educational purpose and for promotion, advertising, trade, and outright showcasing WOLO programs, activities, and its wonderful students! We will never use the full last name.

___ Yes
___ No
___ Case by case basis. Please state usage permitted. _____

Signed Signature: _____ Date: _____
Written Name: _____ Relationship: _____

Please fill out the form below for payment purposes. We will only charge you for services rendered.

PAYMENT METHOD **Please mark the method of payment.*

___ Cash ___ Cheque ___ Credit Card

CREDIT CARD INFORMATION **Please fill in the blank and sign your name.*

___ A credit card number must be on kept on file. All credit cards will be kept private.
___ Your credit card will be automatically charged for late payments, late pickup and/or NSF cheques.

VISA/MASTERCARD/Other: _____ **Name of Cardholder:** _____
Credit Card #: _____ Expiry Date (m/y): _____ CVC (three digit): _____

I, _____ authorize WOLO to automatically use my credit card for **ALL** payments on my account.
Signed Signature: _____ Date: _____

PAYMENT POLICIES **Please initial your name next to each line.*

___ All camps are non-transferable, require a minimum number of registrations to run and may be canceled due to insufficient registrations.
___ WOLO School of Arts does **NOT** provide invoices or reminder notices.
___ In order to reserve my child's space, the full fees must be paid for at the time of booking.
___ All **NSF** cheques will be subject to a $30.00 late fee charge.
___ Full and/or partial refunds will be issued for any programs canceled by WOLO.
___ Full refund requests must be submitted 2 weeks prior to start of camp date. Less than 2 weeks cancellation will result in no refund.
___ All refund requests will include an administration fee of $20 applied to each person and per a transaction.

PARENT AGREEMENT

___ I have read, understood and agree to follow **ALL** policies.
___ I have discussed any questions with the office. I fully understand the policies on the registration forms.
___ I agree to contact the admins immediately to update to my selected payment method.

Signed Signature: _____ Date: _____
Written Name: _____ Relationship: _____