

SUMMER ALTERNATIVES
by
Youth Enhancement Services

Name: _____ **Date of Birth:** _____

Parent(s) / Guardian: _____

Address: _____ **Home Phone:** _____
_____ **Other Phone:** _____

School Attended: _____ **Grade:** _____

Emergency Contact: _____ **Phone:** _____

Source of Referral: _____

Program Weeks (circle all that apply): 6/23-27 6/30-7/3(no 4th) 7/7-11 7/14-18
7/21-25 7/28-8/1

8/4-8/8 8/11-15 8/18-22

Will this camper require 1:1 supervision for health or safety concerns? y / n

Is there 1:1 support already in place? y / n **Name:** _____
Agency _____

Is transportation needed? y / n

List any days/dates he/she will miss because of appts. or vacations during the weeks scheduled above.

COMMENTS / Additional Information (Include Likes / Dislikes; unique needs or

abilities; other challenges):

Physician: _____ **Phone:** _____

List current medications:

List any allergies or medical concerns:

Health Ins. Provider: _____ **Policy #:**

*I give permission for Youth Enhancement Services to access Emergency Services for
_____ as needed.*

Parent / Guardian

Date