



## STEMazzing Summer Camp REGISTRATION

PAL BEFORE and After camp classes  
&  
FULL DAY PAL wen camp is closed

Student \_\_\_\_\_ Date \_\_\_\_\_

Parent (Guardian) \_\_\_\_\_ Cell \_\_\_\_\_

Parent (Guardian) \_\_\_\_\_ Cell \_\_\_\_\_

Address \_\_\_\_\_ Email \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Cell \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Cell \_\_\_\_\_

I give permission for the PAL Staff to **sign out** my child(ren) from PAL **to attend Camp**.  
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Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

You will need to submit these 3 steps BEFORE your child can attend the FIRST DAY

1. **This completed registration form**
2. **The ADHS Emergency information and Immunization Record card**
3. **A copy of current immunizations (only if you were not enrolled in our program AFTER August 2019)**

These 3 forms can be turned in before starting at any of our PAL school site until May 15, scanned and emailed to [info@cep-az.org](mailto:info@cep-az.org) or hand delivered at our office 7632 N La Cholla Blvd. 888-2727.

### FULL DAY PAL (optional)

Harelson Elementary School 826 W Chapala Dr. 85704

THIS IS AT A DIFFERENT LOCATION

Schedule and prices  
For the weeks camp is closed

- |                                                        |                      |                      |
|--------------------------------------------------------|----------------------|----------------------|
| ○ My child will attend the FULL DAY PAL May 26-29      | \$130<br>1-3 days___ | \$175<br>4-5 days___ |
| ○ My child will attend the FULL DAY PAL June 29-July 3 | \$130<br>1-3 days___ | \$175<br>4-5 days___ |
| ○ My child will attend the FULL DAY PAL July 27-31     | \$130<br>1-3 days___ | \$175<br>4-5 days___ |



CDC/SGH# or name: \_\_\_\_\_

**Arizona Department of Health Services  
Bureau of Child Care Licensing  
Emergency, Information and Immunization Record Card**

<b>Child's Name:</b>	<b>Date Enrolled:</b>	Updated:
<b>Home Address (#, Street, City, State, Zip Code):</b>		<b>Date Disenrolled:</b>
<b>Home Phone:</b>	<b>Date of Birth:</b>	<b>Sex:</b> <input type="checkbox"/> male <input type="checkbox"/> female

<b>Parent or Guardian Name:</b>	<b>Home Address (#, Street, City, State, Zip Code):</b>
Cell Phone (optional):	<b>Contact Telephone Number:</b>

<b>Parent or Guardian Name:</b>	<b>Home Address (#, Street, City, State, Zip Code):</b>
Cell Phone (optional):	<b>Contact Telephone Number:</b>

**I authorize the following individuals to collect my child from the facility in case of emergency or if I cannot be contacted:  
(Pursuant to R9-5-304.B, at least two contact persons are required.)**

<b>Name:</b>	<b>Contact Telephone Number:</b>
<b>Name:</b>	<b>Contact Telephone Number:</b>
<b>Name:</b>	<b>Contact Telephone Number:</b>
<b>Name:</b>	<b>Contact Telephone Number:</b>

If Medical care is necessary, call:

<b>Health Care Provider*</b>	<b>Name:</b>	<b>Contact Telephone Number:</b>
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\*A Health Care Provider is a physician, physician assistant or registered nurse practitioner.

<b>In case of injury or sudden illness, I request that this individual be called first:</b>	
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The following individual(s) may NOT remove my child from the facility:

<b>Name(s):</b>
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Custody papers have been provided and are on file at the facility.  yes  no

Telephone Authorization Code (optional): \_\_\_\_\_

**Immunization Information**

(A licensee shall attach an enrolled child's written immunization record or exemption affidavit to the enrolled child's Emergency, Information and Immunization Record card.)

For information regarding current immunization requirements go to:

[www.azdhs.gov/phs/immun/index.htm](http://www.azdhs.gov/phs/immun/index.htm) or contact the Arizona Immunization Program Office at (602)364-3630.

One of these items must accompany the EIIR card at all times:

<input type="checkbox"/>	Copy of current official documented immunization record attached
<input type="checkbox"/>	Religious Beliefs exemption form signed by parent/guardian attached
<input type="checkbox"/>	Medical Exemption form signed by physician and parent/guardian attached
<input type="checkbox"/>	Signed Laboratory Proof of Immunity form attached

Notification of immunizations needed sent to Parent(s) or Guardian(s):	mo /day/ yr	mo /day/ yr	mo /day /yr
Updated immunizations received and attached:	mo /day/ yr	mo /day/ yr	mo /day /yr

**Medical Information**

<p>Is child allergic to food or other substances? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes, describe symptoms, name foods or substances to be avoided, and the procedure to follow if reaction occurs:</p>
<p>Is child usually susceptible to infections and if so, what precautions need to be taken? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes, list precautions:</p>
<p>Is child subject to convulsions and what should be our procedure if one occurs? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes, specify procedure:</p>
<p>Is there any physical condition that we should be aware of and what precautions should be taken (heart trouble, foot problem, hearing impairment, hernia, etc.)? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes, list precautions:</p>
<p>Additional comments:</p>
<p>Other special instructions:</p>

This **Emergency Information and Immunization Record Card** is accurate and complete, front and back, and was provided by:

Parent/Guardian PRINTED Name:	SIGNED Name:	DATE:
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