B"H

GAN ISRAEL DAY CAMP

2615 MICHIGAN ST NE
GRAND RAPIDS, MI 49506
616-957-0770

Date_____

Camper's Name_____ _____ _____
First Last Hebrew

Date of birth____/____/_____ Age_____ Hebrew Birthday_____

Address_____ Phone_____-_____-_____

City_____ State_____ Zip_____

Circle which weeks your child will be attending:

( )Entire session ~ June 20-July 1

( ) Week one ~ June 20-June 24 ( )Week two ~ June 27 – July 1

Father's Name_____ _____ Occupation_____

Email address _____ Cell Phone____-____-_____

Mother's Name_____ _____ Occupation_____

Email address _____ Cell Phone____-____-_____

Medical information

Physician_____ Phone_____-_____

Address_____

List any allergies your child has_____

In case of emergency contact:
Name _____ Phone_____-_____

In an emergency I hereby give permission to Camp Gan Israel to get proper medical treatment for my child named on this form:

Parent's signature_____ Date___/___/_____