



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 24- July 5, 2024
 Week one ~ June 24 - June 28 Week two ~ July 1 - July 5

Father's Name _____
First Last Hebrew

Occupation _____ Email address _____ Cell Phone ____ - ____ - ____

Mother's Name _____
First Last Hebrew

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 ____/____/____