

SUMMER CAMP & TRIP REGISTRATION FORM & PERMISSION SLIP

(PLEASE PRINT CLEARLY)

Child's Name (Last) VOONNA (First) GAGAN ☐ Female ☒ Male

Birth Date 05/08/2007 Age 9 Grade Completed & 16** 3

My child has permission to walk / bike home from the activity site: Check one: ☐ YES ☐ NO

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	MOTHER / GUARDIAN	FATHER / GUARDIAN
NAME (First & Last)	<u>SUSATHA</u>	<u>TIRUJ</u>
ADDRESS (INC. STREET, CITY, STATE, AND ZIP)	<u>13 ALERICA LANE SOMERSET NJ 08873</u>	<u>SAME</u>
HOME PHONE	<u>908 596 5812</u>	<u>202 596 5812</u>
WORK PHONE	<u>908 285 5478</u>	
CELL EMERGENCY PHONE	<u>908 285 5478</u>	<u>202 596 5812</u>
E-MAIL ADDRESS	<u>SUSATHAVOONNA@gmail.com</u>	<u>TIRUMALU@gmail.com</u>

1. Name/Relationship of person(s) other than parent(s) authorized to pick up child: ANTONIE (FRIEND)

2. At Franklin Recreation, it is our goal to provide a safe and rewarding experience for all participants. List relevant information about child's behavior, educational, or medical needs including allergies: NONE

3. List any medications child is using on a daily basis NONE
(Please note Franklin Recreation Department employees CANNOT administer medication to children)

4. List a local contact if parents cannot be reached in an emergency or if child is not picked up on time.

Name	Relationship	Address	Phone
<u>ANTONIE</u>	<u>FRIEND</u>	<u>ALERICA LN, SOMERSET NJ</u>	<u>732 413 3581</u>

5. I will allow my child's picture to be used for display and publicity purposes ☐ YES ☐ NO (No response indicates consent)

FMS CAMP PARENTS ONLY: I give permission for my child to be transported by Franklin Recreation sponsored vehicle for tennis and swimming during the course the 2016 Franklin Middle School Camp program. INITIAL HERE _____

Participants must be able to function in the camp setting with minimal to moderate supervision and support within the typical camp structure. Participants must have the ability to maintain personal hygiene functions specifically toileting needs.

I hereby give Franklin Township Recreation personnel to obtain medical treatment for my child in the event of an emergency when I cannot be contacted. This permission authorizes medical personnel to perform necessary emergency treatment. In extreme emergency, when you cannot be reached, your child will be transported to the nearest hospital.

I have read and agree to abide by the policies and procedures listed herein:

JOY TIRUJ VOONNA
Parent/Guardian Name (Please Print)

[Signature]
Parent/Guardian Signature

05/09/2016
Date