Science Adventure Camp at the Iron Hill Museum & Science Center
2019 Registration Form

Child's Name____ Age________

Parent's Name(s) ____

Address ____

City __________________ State __________________ Zip ____________

Home Phone ______________________ Work Phone ______________________

Parent Cell Phone(s) ____

E-mail* ____

Name of Emergency Contact ________________________ Phone ____________

How did you hear about us? ____

* **E-mail is used to send out confirmation of camp admittance. Your email address will remain confidential.**

SUMMER CAMP TUITION $185.00 per session
EXTENDED CARE $70/week (OR $30 FOR AM ONLY/ $40 FOR PM ONLY)
Please complete a separate registration form for each child

Youth T-shirt size for camper: Small Medium Large XLarge

________	**Earth Explorers**	**June 24-28**	Ages 7-11
________	**Fossil Hunters**	**July 8-12**	Ages 7-11
________	**Ancient Detectives**	**July 15-19**	Ages 9-13
________	**Nature Rangers**	**July 29- August 2**	Ages 7-11
________	**Insect Adventures**	**August 12-16**	Ages 7-13
________	**EXTENDED CARE (see pricing above)**		

SUBTOTAL __________

Minus Delaware Academy of Science member discount (10% off/$17.50 per session) __________

TOTAL AMOUNT DUE __________

Parental Release:
I hereby release the Delaware Academy of Science, Inc., The Iron Hill Museum & Science Center, members of the Executive Council, Committee and instructors from all damages that could occur during these camps.

SIGNATURE ________________________________ **DATE** ______________

RETURN this form with payment to:
Iron Hill Museum
1355 Old Baltimore Pike, Newark, DE 19702
QUESTIONS? 302-368-5703 or director@ironhill-museum.org

Iron Hill Museum Day Camp Student Health Record

Name ____ Sex M F Birth date ______________

Address ______________________________________ Phone _____________________

Illness and Health Problems
Circle those that apply and give additional information if necessary on reverse

Chicken Pox	Frequent Colds	Diabetes
Measles	Frequent Tonsillitis	Allergies (Please specify) __________
Mumps	Hearing difficulty	________________________________
Rubella	Speech difficulty	________________________________
Whooping Cough	Vision difficulty	________________________________
Rheumatic Fever	Menstrual difficulty	________________________________
Orthopedic Concerns	Convulsive disorders	Other: __________________________
Asthma	Heart trouble	________________________________
ADD/ADHD		________________________________

Immunization record: (You may substitute a photocopy of health card/record)
Note: you can obtain DE immunization records quickly at 1-800-282-8672
PLEASE NOTE: WE MUST HAVE A COPY OF THIS AS PER STATE LAW
DTP Series:
MMR:
Polio:
Tuberculin test: Date _________ Result: ___________

Please inform us of any other condition we should be aware of. This information is confidential and will enable us to better serve your child:
____
____
____

Designated Adult Emergency Contact/Persons Authorized to Pick Up Child:

(1) Name: ____ Relation to Child: ___________________

Address: ____ Phone: _______________________

(2) Name: ____ Relation to Child: ___________________

Address: ____ Phone: _______________________

I, ____, hereby give authorization for emergency medical care to be administered to my child, __________________________________, in the event that an emergency occurs and I am unable to be contacted in a timely manner.

Signature: ____ Date: ______________________

PLEASE RETURN COMPLETED HEALTH FORM NO LATER THAN 6/1/19- THANK YOU!

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