

# Holy Angels Presents...

## Camp Angels

June 22- August 14

7 am - 6 pm

Join us for some Summer Fun!

Sports, Crafts, Bikes & Scooters, Summer Reading Help, Library Time,

Movie Fridays

&

Much Much More!

For more Information Contact Camp Director, Clive Kelly

Phone: (626) 864-4452

Email: [ckelly@holyangelsarcadia.org](mailto:ckelly@holyangelsarcadia.org)



# SUMMER CAMP

Summer Camp at Holy Angels features a variety of fun summer activities for students entering Kinder thru 6<sup>th</sup> grade.

The Camp is staffed with one counselor per 9 students

The camp is run at our enclosed secure campus

Activities will include, Soccer, Volleyball, Basketball, Golf, Legos, Board Games, Library time, summer reading, book club, arts and crafts, Friday movie and popcorn afternoon.

Bicycles and scooters (with proper safety equipment) are allowed and may be stored at camp during your camp stay

Snack, juice and water provided daily. Pizza lunch provided on Fridays

You may sign up for camp for one day, one week, afternoons, or the entire time. We will work with your schedule to best suit your needs

Holy Angels Summer Camp  
Please complete one form for each child  
 Return by May 31, 2011

Child's Name \_\_\_\_\_ Grade Entering \_\_\_\_\_ School \_\_\_\_\_  
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Mother's Last Name \_\_\_\_\_ First \_\_\_\_\_  
 Home address: \_\_\_\_\_  
 City \_\_\_\_\_ Zip \_\_\_\_\_ Home phone (\_\_\_\_) \_\_\_\_\_  
 Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Father's Last Name \_\_\_\_\_ First \_\_\_\_\_  
 Home address: \_\_\_\_\_  
 City \_\_\_\_\_ Zip \_\_\_\_\_ Home phone (\_\_\_\_) \_\_\_\_\_  
 Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

<b>Weekly Rate: 7 am-6 pm</b>	<b>Afternoon Rate: 1-6 pm</b>	<b>Daily Rate: 7am-6 pm</b>
1 child \$200.00	\$100 for Monday-Friday	\$60 for 1 day
2 children \$360.00	per child	\$110 for 2 days
3 children \$500.00		\$150 for 3 days

Special arrangements can be made to accommodate most families  
**Registration fee \$+.00 per family (non refundable)**

Please indicate times and weeks that you are registering for:

Weeks	Weekly	Afternoon	Daily (fill in dates)
1. 6/2G-6/2I	_____	_____	_____
2. 6/GJ-7/3 <del>AAA</del> <del>AAAAAAAAA</del>	_____	_____	_____
3. 7/I - 7/1E	_____	_____	_____
4. 7/1H- 7/1I	_____	_____	_____
5. 7/2E-7/2I	_____	_____	_____
6. 7/2I - 7/2F	_____	_____	_____
7. 8/H- 8/I	_____	_____	_____
8. 8/1E- 8/1I	_____	_____	_____

Amount \$ \_\_\_\_\_ + \$1.00 registration fee = Total Due \$ \_\_\_\_\_

***I understand that for my child's safety the camp is staffed with one counselor per 9 children. For this reason I understand that I will be held financially responsible for the dates that I enroll my child/children regardless of whether or not they attend. I also understand that once the program starts I cannot withdraw from the weeks I have chosen.***

**Parents Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Family Last Name:		
<b><i>FAMILY INFORMATION</i></b>		
Student's Name:		
Primary School:		
Home Phone:		
Home Address:		
Mother's Work Phone #	Cell Phone #	
Father's Work Phone #	Cell Phone #	
Mother's Name:		
Mother's Occupation:	Employer:	
Work Address:	Hours:	
Father's Name:		
Father's Occupation:	Employer:	
Work Address:	Hours:	
Child lives with: (circle) Both Natural Parents    Mother only    Father only		
	Mother/Stepfather	Father/Stepmother
	Guardian	Other
<b><i>STUDENT INFORMATION</i></b>		
Student's Last Name:	First:	Middle:
Grade in September:	Birth date:	
Sex: (circle) Male    Female    Glasses: Yes    No    Contact Lenses: Yes    No		
Medical Alert (conditions requiring special emergency care)		
Asthma:	Health Problems:	
Allergies:	Medication (taken regularly)	
History of seizures: Yes    No		
Student's Name:		
Health Insurance Carrier name and address:		
Group number:	Subscriber Number:	
Doctor's name:	Phone number:	
Dentist's name:	Phone number:	

Student's Name:		
<b><i>EMERGENCY CARE INFORMATION</i></b>		
Additional persons permitted to take student from school:		
1.) Name:	Relationship to student:	
Address:	City:	Zip code:
Phone #:	Additional phone #:	
2.) Name:	Relationship to student:	
Address:	City:	Zip code:
Phone #:	Additional phone #:	
3.) Name:	Relationship to student:	
Address:	City:	Zip code:
Phone #:	Additional phone #:	
<b><i>EARTHQUAKE-DISASTER RELEASE INFORMATION</i></b>		
To be completed for each student by school official in the event of an earthquake-disaster		
Student's Name:	was released to:	
Date:	time:	
Location to which child taken:		
School Official releasing child:		
Student's Name:	was released to:	
Date:	time:	
Location to which child taken:		
School Official releasing child:		

## Consent

I understand that the school does not assume responsibility for payment of physician or any medical or dental services. However, in an emergency the school may choose a physician. In an emergency I give Holy Angels School and/or any School Official permission to have my child receive medical treatment.

Signature of:

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Parent/Guardian

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Parent/Guardian