525 Rapides St.
Baton Rouge, LA 70806
Phone: (225) 928-0801
mckenna@kidscountbr.com

2025 SUMMER CAMP REGISTRATION

CHILD INFORMATION

First Name: _____ M.I. _____ Last Name: _____

Name child prefers to be called: _____

Date of Birth: _____ Sex: [ ] Male [ ] Female

Address:

_____

_____

PARENT OR GUARDIAN INFORMATION

Parent/Guardian #1

First Name: _____ M.I. _____ Last Name: _____

Occupation: _____ Employed By: _____

Contact Information:

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone Carrier: _____

Email: _____

[ ] Custodial Parent (if married, mark off both)

Parent/Guardian #2

First Name: _____ M.I. _____ Last Name: _____

Occupation: _____ Employed By: _____

Contact Information:

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone Carrier: _____

Email: _____

[ ] Custodial Parent (if married, mark off both)

Automated Payment Processing

Procare SOLUTIONS

Safe. Convenient. Easy.

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT AND CREDIT CARD

I (we) hereby authorize (business name) KIDS COUNT OPCO LLC to initiate credit card charges to the below-referenced credit card account (Section A) OR, initiate debit entries to my (our) checking or savings account, indicated below (Section B). To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name | Phone #

Cardholder Address | City | State | Zip

Account Number | Expiration Date

Cardholder Signature | Date

SECTION B (Bank Account)

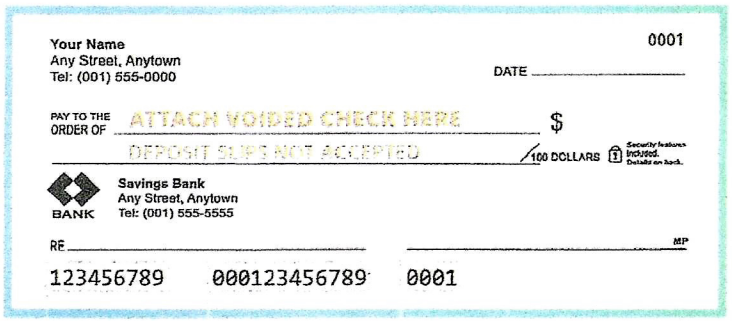
Your Name | Phone #

Address | City | State | Zip

Bank or Credit Union Name | Bank or Credit Union Address | City | State | Zip

Routing Transit Number (see sample below) | Account Number (see sample below) | ☐ Checking ☐ Savings

Authorized Signature | Date



FOR OFFICIAL USE ONLY

Date Received

Employee Signature

800.338.3884 • procaresoftware.com

EMERGENCY CONTACTS/AUTHORIZED PICK-UPS:

Persons Authorized to Pick up Child:

1. First & Last Name: _____ Contact Number: _____
   Relationship to Child: _____ Emergency Contact: [ ] Yes [ ] No
2. First & Last Name: _____ Contact Number: _____
   Relationship to Child: _____ Emergency Contact: [ ] Yes [ ] No
3. First & Last Name: _____ Contact Number: _____
   Relationship to Child: _____ Emergency Contact: [ ] Yes [ ] No
4. First & Last Name: _____ Contact Number: _____
   Relationship to Child: _____ Emergency Contact: [ ] Yes [ ] No

Person(s) which whom the child lives: _____
_____

Does your child have any food allergies?	Yes	No
Does your child have any other allergies?	Yes	No
Does your child have any dietary restrictions?	Yes	No
Does your child have any special needs or health concerns?	Yes	No

Please explain any "yes" answer here: _____
_____
_____
_____

Parent/Guardian Signature: _____ **Date:** _____

PERMISSION FOR HEALTHCARE

Child's Full Name: _____

Child's Physician

Name: _____ Phone: _____

Address:

_____

_____

AUTHORIZED ADULTS:

In the event of an emergency, please indicate your name and phone number where you and another authorized person can be reached:

Parent/Guardian #1's Name: _____ Phone: _____

Parent/Guardian #2's Name: _____ Phone: _____

Another Authorized Person: _____ Phone: _____

FIRST AID:

In the event of an emergency, I authorize the staff to provide any first aid care deemed necessary for my child.

_____ _____

Date **Parent/Guardian Signature**

EMERGENCY CARE:

In the event of an emergency in which I cannot be reached, the physician listed above, and the local hospital, are hereby authorized to provide any emergency care deemed necessary for my child.

_____ _____

Date **Parent/Guardian Signature**

HEALTH RECORD TRANSFER

In the event of an emergency, I hereby authorize the transfer of my child's health record to the local hospital.

_____ _____

Date **Parent/Guardian Signature**

AUTHORIZATION FOR THE APPLICATION OF TOPICAL PRODUCTS

Child's Name:

_____

I give permission for Kids Count staff to apply the following topical products (parent-provided) to my child.

YES	NO	
[ ]	[ ]	**SUNSCREEN**
[ ]	[ ]	**INSECT REPELLANT**
[ ]	[ ]	**DIAPER RASH OINTMENT**
[ ]	[ ]	**OTHER:** _____

This one-time authorization will remain in effect until a new authorization is signed.

_____	_____	_____
Parent/Guardian Signature	**Print Name**	**Date**

WATER ACTIVITIES AUTHORIZATION

My child, _____, has permission to participate in the following type(s) of water activity:

Outdoor water sprinklers on designated "Water Days" and/or water tables for science/sensory activities

Location of activity: Kids Count Playground or classrooms

_____	_____	_____
Parent/Guardian Signature	**Print Name**	**Date**

children under the age of 2 will not participate in any water activities