



**PEDIATRIC PSYCHOLOGY**  
ASSOCIATES

**Social Skills Intensive Camp Registration Form**  
**Form must be completed by all Families**

**Child's/Camper's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Parent(s)/Caregiver(s) Name:** \_\_\_\_\_

**Parents Contact information:** \_\_\_\_\_

**Parent(s) Email address(es):** \_\_\_\_\_

**Emergency Contact-Name and Phone #:** \_\_\_\_\_

**School and Grade Child Attends:** \_\_\_\_\_

**Home Address, City, State and Zip:** \_\_\_\_\_

**Please circle which Intensive Camp Session(s) you will be attending:**

**Coral Springs (6/13 - 6/17)    Aventura (6/20 - 6/24) (8/8 - 8/12) (8/15 - 8/19)    Coral Gables (8/8 - 8/12)**

Does your child have any dietary restrictions (allergies, kosher, gluten-free)? If so, please list: \_\_\_\_\_

Please list any goals/expectations you may have for your child's camp experience: \_\_\_\_\_

What activities does your child enjoy doing? \_\_\_\_\_

Please tell us anything else that would be important for us to know about your child: \_\_\_\_\_

\_\_\_\_\_

***Consent for Camp Services***

I voluntarily give consent for treatment by *Pediatric Psychology Associates* for myself and/or my family members. I understand the purpose of the camp is to assist in the formation and development of improved social skills and emotional health. I am free to withdraw my consent at any time without penalty to me or my child.

I understand that camp sessions may be taped for the purpose of ongoing assessment and training of group participants. *Pediatric Psychology Associates* will not release confidential material to other outside parties without written permission. As provided by law, confidentiality may only be breached for protection purposes when the client is imminently dangerous to her/himself or others, or in cases of child abuse.

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

**Print Name:** \_\_\_\_\_ **Relation to child** \_\_\_\_\_



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**Child's/Camper's Name:** \_\_\_\_\_

Please Read and Initial:

\_\_\_\_\_ Please note our camp sessions are weekly and to create the most therapeutic and successful experience for each child, we need full participation from all families unless different arrangements are made in advance. Please bring your child to all sessions unless there is an emergency that cannot be foreseen. Refunds for missed days are given with advance notice or prior arrangements made with the office. Our goal is to promote and enhance social skills and when members are absent this affects the social facilitation and the therapeutic experience for everyone. We hope you are sensitive to this issue and make a commitment to attend daily.

**Fees and Payment Options for Camp:**

**\$50 Registration Fee- Due at time of Sign up or by date of Consultation.**

Registration fee includes ½ hour initial consult to set goals and for child/parents to meet camp coordinator, and covers the cost of materials

**\$300 per week-Camp fees are due the Friday prior to the first date of camp**

**Please initial one:**

\_\_\_\_\_ I will pay \$300 by cash or check (on or before the Friday of my child's camp)

\_\_\_\_\_ I will pay \$300 by credit card (my credit card will be charged the Friday prior to my child's camp). Below is my credit card information. This option is recommended.

Name on Card \_\_\_\_\_

I authorize *Pediatric Psychology Associates* to charge my credit card as follows:

Please Circle *\$50 Registration Fee* *\$300 Per Camp session fee*

Type of Card:  Visa  MasterCard  **We do not Accept AMEX** Expiration Date \_\_\_\_\_

Credit Card Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_, CVV Number \_\_\_\_\_ A 3-digit number in reverse italics on the **back** of the credit card

Card Holder's Billing Address for Credit Card Statements

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**PLEASE SIGN- Signature** \_\_\_\_\_ **Date** \_\_\_\_ / \_\_\_\_ / \_\_\_\_