PEDIATRIC PSYCHOLOGY
ASSOCIATES

Summer Camp Programs 2015 Registration Form

Please forward forms via fax (305) 936-1022 or email to info@mailppa.com

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:_____

Individuals authorized to pick up your child:_____

Please *CIRCLE* which Camps and Dates your child will be attending:

Social Skills Intensive Camp (9 am – 12 pm)*: Maximum of 8 campers/Minimum of 4 campers to run session

Coral Gables: Week 1: 6/15-6/19 Week 2: 8/3-8/7

Fun-gineering (Lego) Social Skills Camp (9 am – 12 pm)*: Maximum of 8 campers/Minimum of 4 campers to run session

Aventura: Week 1: 8/3 – 8/7

*Additional services can be provided following ½ day camps (individual therapy & testing) with advanced arrangement.

Surf & Paddleboard Camp (9 am – 3 pm): Maximum of 12 campers

Surfside Community Center: Week 1: 8/10 – 8/14 Week 2: 8/17 – 8/21

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 patient is imminently dangerous to her/himself or others, or in cases of child abuse.

Signature: _____ **Date:** _____

Print Name: _____ **Relation to child**_____

2925 Aventura Boulevard, Suite 300
Aventura, FL 33180
(305) 936-1002

7301 Wiles Road, Suite 106
Coral Springs, FL 33067
(954) 753-1112

1390 South Dixie Highway, Suite 1305
Coral Gables, FL 33146
(305) 662-9162

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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. 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.
$350 per week- Social Skills Intensive Camp and Fun-gineering (Lego) Social Skills Camp
$500 per week- Surf and Paddleboard Camp

All camp fees are due fourteen (14) days prior to the first date of camp
In order to provide adequate staffing and preparations for the camp, please note that cancellation less than 7 days prior to camp and no show or missed days will not be refunded.

Please initial one:

_____ I will pay $_____ by cash or check (on or before 14 days prior to the first day of camp)

_____ I will pay $_____ by credit card (your credit card will be charged 14 days prior to the first day of camp). Registration will be charged at time of sign up or initial consultation. 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*** ***Amount based on camp attending $_____ Per Week***

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 ___ /_____ /____