Your Child's Last Name: ____

Counselor-in-Training (CIT) Application for

CCS CAMPUS

Session 2 - July 10 to July 21, 2017 - Monday to Friday (2 weeks)

$550

FAMILY INFORMATION

FULL NAME PARENT #1		WORK PHONE	CELL/PAGER
FULL NAME PARENT #2		WORK PHONE	CELL/PAGER
HOME ADDRESS		HOME PHONE	
CITY	ZIP	EMAIL (Required)	
EMERGENCY CONTACT		RELATIONSHIP	PHONE/CELL
FAMILY DOCTOR			PHONE

FIRST CHILD (STUDENT #1)

LAST NAME	FIRST	SEX	BIRTHDATE
CURRENT SCHOOL		GRADE IN FALL	

SECOND CHILD (STUDENT #2)

LAST NAME	FIRST	SEX	BIRTHDATE
CURRENT SCHOOL		GRADE IN FALL	

THIRD CHILD (STUDENT #3)

LAST NAME	FIRST	SEX	BIRTHDATE
CURRENT SCHOOL		GRADE IN FALL	

TUITION CALCULATION

STUDENT #1 - $550	$
STUDENT #2 - $550	$
LESS 5% DISCOUNT ON 2nd CHILD ONLY OF $28	**-$**
STUDENT #3 - $550	$
TOTAL TUITION , CHECK ENCLOSED FOR: PLEASE MAKE CHECK OUT TO THE CHILDREN'S ARTS INSTITUTE	$

*** If using credit card, add 3% of total of above first 6 lines.**

PLEASE CHARGE MY VISA OR MASTERCARD

I authorize The Children's Arts Institute to charge my credit card for camp tuition and other camp fees.

TOTAL TUITION AND FEES $__________

VISA ___ MASTERCARD ___ CARDHOLDER NAME ____

ACCOUNT # ____ EXP. DATE: _________________________

BILLING ADDRESS ____

CARDHOLDER SIGNATURE: ____

I understand that the use of a credit card will result in 3% being added to the fees.

HOW DID YOU HEAR ABOUT US?

FRIEND _______ SCHOOL FLYER______ INTERNET______ OTHER _________________________

TERMS AND CONDITIONS

1. **ENROLLMENT OPTIONS:** The Counselor-in-Training program is a five day a week program. Occasionally we will accept a student for MWF enrollment only but, as spaces for this program are limited, priority is given to students who enroll for all five days.

2. **MEDICAL INFORMATION:** Your child's health and safety is important to us. The medical form below must be on file with us prior to your child's first day at camp. Please advise us in advance of any special medical needs your child may have.

3. **ABSENCES:** There are no makeup days for absences or for days missed and parents are financially responsible for all days that their child has registered to attend. There will be no prorating of tuition for days missed due to sickness or travel, or any other reason.

4. **TUITION:** Full tuition must accompany each application in order for your child to be registered for workshops. A 5% discount is offered for a second sibling enrolled in the same session from the same immediate family. Please make all checks payable to the Children's Arts Institute. MasterCard and Visa credit cards are accepted; however a 3% finance charge will be added to the fees. There is a $10 fee on all returned checks.

7. **WITHDRAWALS AND REFUNDS:** Should you withdraw from the summer program prior to June 1, 2017 you will receive a full refund minus a $100 cancellation fee per child **per** session enrolled. After June 1, 2017, there will be no refunds. If a child is dismissed from our summer program for disciplinary measures, there will be no refund for any unused days. There are no exceptions to this policy.

REGISTRATION CANNOT TAKE PLACE WITHOUT A COMPLETED APPLICATION, SIGNATURE, DATE, MEDICAL FORM, AND FULL TUITION

I have read, understand and agree to the Children's Arts Institute terms and conditions. I further agree to:

1 Pay for any additional fees if extended care is used on an occasional basis.
2 Allow my child's image to be used in any and all promotional photographs, videos or websites and brochures
3 Not hold the Children's Arts Institute responsible for any articles of clothing or personal belongings that are lost or damaged by theft, fire, natural disaster or another occurrence.

PARENT/GUARDIAN SIGNATURE ___________________________________ DATE: ____________

YOUR WORKSHOP CONFIRMATION WILL BE SENT TO YOU BY EMAIL.

MAIL REGISTRATION FORM TO 14702 SYLVAN STREET, VAN NUYS, CA 91411
OR, IF PAYING BY CREDIT CARD, YOU MAY FAX REGISTRATION FORM TO 818-780-5834
OR SCAN AND EMAIL TO GEORGE@CCSTEACHES.ORG

The Children's Arts Institute is part of the non-profit Foundation for Excellence in Education

MEDICAL INFORMATION FORM
CCS CAMPUS – SESSION TWO – MTWTHF

MEDICAL BACKGROUND	CHILD #1	CHILD #2	CHILD #3
Your child's first name and last name			
CURRENT HEALTH CONDITIONS			
Epilepsy/Convulsions	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Heart Defect / Disease	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Bleeding / Clotting Disorder	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
IMMUNIZATIONS			
Chicken Pox	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Measles	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
German Measles	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Mumps	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
ALLERGIES			
Insect Stings	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Penicillin	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other Drugs	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Food	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Please comment on "Yes" answers to Current Health Conditions or Allergies			
Medications to be administered at camp			

EMERGENCY AUTHORIZATION

I, the undersigned parent / guardian of said minor, do hereby certify that my child(ren) is (are) physically and mentally able to participate in camp activities. In the event of illness or accident I hereby grant full authority to the Children's Arts Institute to take whatever actions it may consider to be warranted under the circumstances regarding the health and safety of my child(ren). Such authority shall include the power to consent to any X-ray examination, anesthesia, medical or surgical diagnosis or treatment, and hospital care under the supervision of a licensed medical practitioner, or to consent to an X-ray examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care to be rendered by a licensed dental practitioner. Any such diagnostic treatment or care shall be rendered at my expense. In the event of injury or illness I understand that due effort to contact me to assist in any decision will be made by the Children's Arts Institute, but that said Institute will be compelled to use its best judgment should it not be possible to contact me. I hereby indemnify the Children's Arts Institute and any director, teacher or counselor from any liability because of the exercise of such consent.

____
Signature of Parent or Guardian

____
Please Print Parent's or Guardians Full Name

____
Date

Children’s Arts Institute
Emergency Contact and Pick-Up Authorization Form

Child’s
Name____

Parent’s
Name____

Please circle which session(s) your child will be attending.

Session 1 Session 2 Session 3

EMERGENCY CONTACT	RELATIONSHIP	PHONE/CELL
FAMILY DOCTOR		PHONE
AUTHORIZED PERSON(S) TO PICK UP MY CHILD(REN)		