Adventure Academy Inc Admission Application

Enrollment Date: _____ Enrollment Termination Date: _____

Child's Name: _____ Preferred Name/Nickname: _____ DOB: _____

Child's Age: _____ Phone Number: _____ E-mail: _____

Home Address: _____

Allergies & Other Medical Conditions (i.e. asthma, diabetes, epilepsy, physical limitations, ect.)
Medical Plan for Allergic Reactions: _____
_____
_____
_____

Please mark the appropriate times your child/children would be attending Adventure Academy:

_____ Mon _____ Tues _____Wed _____ Thurs _____ Fri

Drop Off: _____ a.m. Pick-up: _____ p.m. Grade: _____

Mother's Name: _____ Home Phone: _____
Cell Phone: _____ Text: Y / N E-mail: _____
Home Address: _____
Work Name: _____ Work Phone: _____
Work Schedule: _____

Father's Name: _____ Home Phone: _____
Cell Phone: _____ Text: Y / N E-mail: _____
Home Address: _____
Work Name: _____ Work Phone: _____
Work Schedule: _____

In an Emergency Contact:
Name of Doctor: _____ Office Number: _____
Person Authorized to Act for Parents:
Name: _____ Relationship: _____
Cell Number: _____ Home Number: _____

Parents Signature: _____ Date: _____