



**SUMMER CAMP 2026
PROGRAM FORM**

CHILD'S NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ CURRENT SCHOOL: _____

PHONE(s): _____ GRADE ENTERING SEPT 2026: _____

PARENT'S EMAIL: Dad _____ Mom _____

I would like my child to: REST from 1:00 - 1:30 () NAP from 1:00 - 3:00 () OR Neither ()

PLEASE SELECT T-SHIRT SIZE: (1 shirt is included with the activity fee)

() X-SMALL 2-4 () SMALL 6-8 () MEDIUM 10-12 () LARGE 14-16 () ADULT SMALL 34-36

(X) THE HOURS, DAYS AND WEEKS DESIRED:

HOURS

() HALF DAY: 9:00am - 12:00pm
() SCHOOL DAY: 9:00am - 3:45pm
() EXTENDED DAY: 7:00am - 5:30pm

DAYS

() 5 DAYS: MONDAY THROUGH FRIDAY
() 4 DAYS: _____, _____, _____, _____
() 3 DAYS: _____, _____, _____
() 2 DAYS: _____, _____

Check (X)
Weeks

WEEKS

JUNE 22 - JUNE 26

*JUNE 29 - JULY 2

JULY 6 - JULY 10

JULY 13 - JULY 17

JULY 20 - JULY 24

JULY 27 - JULY 31

AUGUST 3 - AUGUST 7

AUGUST 10 - AUGUST 14

AUGUST 17 - AUGUST 21

AUGUST 23 - AUGUST 29

INDICATE SPECIFIC
DAYS REQUESTING

M T W Th F

M T W Th --

M T W Th F



* CLOSED July 3rd in observance of Independence Day.

OVER





Please return this form with your activity fee & deposit upon registration.

Child's Name _____

Grade Entering in Sept. 2026 _____

Address _____

Date of Birth _____

Mother's Name _____

Home # _____

Cell Phone # _____

Business Phone # _____

Father's Name _____

Home # _____

Cell Phone # _____

Business Phone # _____

Persons Authorized (in addition to parents) To Pick Up Child In Case Of Emergency: REQUIRED

Name _____ Phone # _____ Relationship _____

Name _____ Phone # _____ Relationship _____

Allergies: Please circle:

Bee Stings	yes	no
Insect Bites	yes	no
Poison Ivy	yes	no
Penicillin	yes	no
Aspirin	yes	no

Please list ANY medication(s) child is NOW taking:

Please list ANY illness for which child is under medical care:

Has child had ANY of the following?

Epilepsy	yes	no
Heart Trouble	yes	no
Fainting Spells	yes	no
Convulsions	yes	no
Asthma / Wheezing	yes	no
Heat Exhaustion/Heat Stroke	yes	no
Frequent Stomach Upsets	yes	no
Does Camper Wear Ear Plugs?	yes	no
Does Camper Wear Glasses?	yes	no

Food Allergies: Please list: _____

Medication Allergies: Please list: _____

Please list ANY serious illnesses your child has had _____

Should Camper's activities be restricted in ANY way? _____

Child's Doctor _____ Doctor's Phone # _____

Hospital Preference _____

NOTE * Any child needing prescription medication administered during camp must have forms filled out and signed by parent for dispensation of medication. These forms are available at the Les Enfants office.

I attest that my child is in good health and can participate in all Summer Camp activities. Furthermore, he/she has been examined by a physician within one year prior to the date of registration. In the event that a medical emergency occurs, I authorize Les Enfants to seek emergency medical care for my child.

I grant permission for my child to use all indoor and outdoor play equipment in the Les Enfants program and participate in all Camp activities, including supervised neighborhood walks, walking field trips, and activities at local parks.

I grant permission for my child and/or staff to apply and or reapply sunscreen as needed.

My child has permission to use all the swimming and playground facilities at the Palisades Park Swim Club 200 Roosevelt Pl, Palisades Park as well as travel on a seat belted bus to and from Les Enfants Preschool to the Palisades Park Swim Club. Bussing will be provided by First Student 170 South Dean Street, Englewood, NJ.

I have read, understand and agree to abide by the Summer Camp Payment Policies and policies set forth in the Les Enfants Family Handbook. These policies include the Information to Parents Document and the Les Enfants Discipline Policy.

Parent or Guardian's Signature _____ Date _____

OVER

