# FIDELITY HOUSE DAY CAMP 2010 REGISTRATION FORM

**25 MEDFORD STREET, ARLINGTON, MA 02474 - 781-648-2005 www.fidelityhouse.org**

**Please fill out the one page registration form per child** and leave a deposit. **A $50.00 NON-REFUNDABLE deposit per week** (per child) is required to hold the spot. It will be credited toward the camp fee **and is not an additional fee**. Registration deadline for each week/session of camp is the preceding Friday at 5 p.m. A $20 late fee will be applied to registrations after 5 p.m.

| Dates | One Week | Two Weeks | Six Weeks |
|---|---|---|---|
| June 28— July 2 | $220 | | |
| July 6 — July 9 *NO camp July 5 | $180 | $380 | |
| July 12 - 16 | $220 | | $1.200 |
| July 19 - 23 | $220 | $425 | |
| July 26— July 30 | $220 | | |
| August 2 – Aug. 6 | $220 | $425 | |

EXTENDED CARE FEES

Prepaid in Advance

**1 HOUR-4:30 - 5:30**

$50 per 2 wk. session $25 per week

**2 HOURS/4:30 - 6:30**

$110 per 2 wk. session $55 per week

Extended Care for Campers ***not previously signed up*** will be provided at a rate of $3.00 per 15 minutes- **payable at pick up of that day.**

**PLEASE FILL OUT INFORMATION COMPLETELY & CLEARLY. DEPOSITS, CHILD INFORMATION SHEETS & MEDICAL IMMUNIZATION FORMS REQUIRED before attendance**

**Name _____ Male ____ Female ____**

**Date-of-Birth ___ / ____ / _____ Grade Entering _____ Age _____**

**Phone No. (____) _____family email _____**

**Address _____**

**Town _____ Zip _____**

**Mother's Name & Day Phone _____ (____) _____**

**Mom Cell No. (____) _____**

**Father's Name & Day Phone _____ (____)_____**

**Father Cell No. ( ____) _____**

**Emergency Name & Phone _____ (____)_____**

**(called ONLY if parents unavailable)**

T-Shirt Size- *Campers receive one prior to all camp trips and should wear it on trip day*

*ch small(6-8)___ ch. Med (10-12) __Ch. Lg (14-16)___ Ad. S __ Ad. M __ Ad L__ Ad XL ___*

**I give my permission for my child, _____to attend Fidelity House Day Camp and in no way hold Fidelity House, its staff or sponsors responsible for any accident, injury or illness to my child while attending the program.** _____

**Parent/Guardian signature Date**

Office use, * other side

**Grades 1-5**

## *Please indicate TWO WEEK Sessions here:*

☐ **Session I- June 28 – July 9 ($380) *no camp 7/5**
Ext. Care 1 hr ($)___or 2 hrs( $) _____ **Total $_____**

☐ **Session II- July 12 –July 23 ($425)**
Ext. Care 1 hour ($50)___ 2 hrs ($110 ) _____ **Total $_____**

☐ **Session III- July 26 –August 6 ($425)**
Ext. Care 1 hour ($50)___ 2 hrs ($110) _____ **Total $ _____**

☐ **ALL THREE SESSIONS I,II,III ($1,200)**
Ext. Care 1 hr ($150 )___or 2 hrs( $ 330 ) _____ **Total $_____**

## *Please indicate ONE WEEK Registrations here:*

☐ **Week 1- June 28 – July 2 ($220)**
Ext. Care 1 hour ($25)__ 2 hrs ($55)_____ **Total $ _____**

☐ **Week 2- July 6 – 9 ($180) *no camp 7/5**
Ext. Care 1 hour ($25)___ 2 hrs ($55)_____ **Total $ _____**

☐ **Week 3 - July 12– 16 ($220)**
Ext. Care 1 hr. ($25) ___ 2 hrs ($55) ____ **Total $ _____**

☐ **Week 4 – July 19- 23 ($220)**
Ext. Care 1 hr ($25) ___ 2 hrs ($55)____ **Total $_____**

☐ **Week 5 – July 26 – July 30 ($220)**
Ext. Care 1 hr ($25)___ 2 hrs ($55) ___ **Total $ _____**

☐ **Week 6 – August 2 – Aug. 6 ($220)**
Ext. Care 1 hr ($25)___ 2 hrs ($55) ___ **Total $ _____**

**Grand Total $_____**

For OFFICE USE ONLY

| DATE | RECEIPT | AMT. DUE | AMT. PAID | BALANCE |
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**OFFICE USE ONLY-**

| DATE | REGISTRATION REVISIONS | ADDITIONAL NOTES | Changes in Computer/Initials |
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