

**WEST PARK CULTURAL CENTER**

Mailing Address: 5114 Parkside Avenue \* Philadelphia, PA 19131

215/473-7810 [www.westparkcultural.org](http://www.westparkcultural.org)

**CAMP GINKGO / GINKGO ACADEMY REGISTRATION**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Male \_\_\_ Female \_\_\_  
(please print)

Name of Parent/Guardian \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_/\_\_\_\_/\_\_\_\_ Daytime Phone \_\_\_\_/\_\_\_\_/\_\_\_\_ Cellular \_\_\_\_/\_\_\_\_/\_\_\_\_

Email \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_/\_\_\_\_/\_\_\_\_

Name(s) of persons authorized to pick up your child \_\_\_\_\_  
\_\_\_\_\_

Does your child have permission to leave on his/her own? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, describe manner of travel (walking, bus, bike, etc.) \_\_\_\_\_

**Medical Information**

Insurance Provider \_\_\_\_\_ Insurance Group # \_\_\_\_\_

Name of Child's Physician \_\_\_\_\_ Phone \_\_\_\_/\_\_\_\_/\_\_\_\_

List of medical conditions child may have \_\_\_\_\_

List of any prescription medication your child is taking \_\_\_\_\_  
\_\_\_\_\_

I, \_\_\_\_\_ (parent/guardian name) give permission for  
\_\_\_\_\_ (child) to participate in West Park Cultural  
Center's Camp Ginkgo/Ginkgo Academy to be held at the Fairmount Park Horticulture Center. I  
understand the **camp period each week is Monday thru Friday from 8:00am to 3:00pm** with possible  
extended days to accommodate out-of-town trip(s). I further understand that **if my child is picked up  
after 3:00pm on regular days, I will be charged a \$10 extended day fee.**

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date