

2024 WJNS SUMMER REGISTRATION

408 North Judd Street, Honolulu, HI 96817 · (808) 531-5252 · www.wjns.org

2024 SUMMER ENRICHMENT & J CAMP @ WJNS, GRADES K-5

A NON-REFUNDABLE application/activity fee of \$100 is due with completed application

*WJNS Students: Priority enrollment deadline is March 15, 2024

**A detailed calendar and menu will be delivered via email outlining the summer program schedule of events in May.

SUMMER PROGRAM FULL DAY:

June 3 – 28, 2024

July 1 – 19, 2024

· Summer Enrichment 8:00 am – 11:30 am (snack provided)
(student drop off is 7:00 am – 8:00 am)

· J Camp 8:00 am – 5:00 pm (lunch and snacks provided)
(student drop off is 7:00 am – 8:00 am)

· J Camp 11:30 am – 5:00 pm (lunch and snack provided)

STUDENT INFORMATION

Name: _____ Birthday: ___/___/___ Male Female

Address: _____ City/Zip: _____

School: _____ Current Grade ('23-'24 SY): _____

Language Spoken at Home: _____

T-shirt Size: Youth Small Youth Medium Youth Large Youth X-Large Adult Small Adult Medium

PAYMENT PLAN: Select one of the following:

I will be making a full program payment of \$1,400 by June 3, 2024, to the school office. I understand that failure to provide payment by this date may result in the removal of my student from this program.

I will be making two payments of \$700, totaling \$1,400 scheduled for June 3, 2024, and July 1, 2024, through FACTS Management.

**Only available for current WJNS students. WJNS will be finalizing FACTS charges by May 20, 2024*

FOR OFFICE USE ONLY

APPLICATION RECEIVED DATE: _____ RECEIVED BY: _____

APP FEE PAID: y/n HOW PAID? _____ RECEIPT GENERATED DATE: _____

PAYMENT PLAN:

FULL SUMMER: _____ PAYMENT #1: _____ PAYMENT #2: _____

PARENT INFORMATION

Name: _____ Father Mother

Address: _____

City/Zip: _____ E-mail Address: _____

Phone Number: _____ Home Mobile Alt. Number: _____ Home Mobile

Employer Name: _____ Work Phone Number: _____

Name: _____ Father Mother

Address: _____ check if same as above

City/Zip: _____ E-mail Address: _____

Phone Number: _____ Home Mobile Alt. Number: _____ Home Mobile

Employer Name: _____ Work Phone Number: _____

POLICIES AND PERMISSIONS

I agree: *(please initial)*

_____ WJNS J Camp has my permission to use photographs and/or video footage of my child for its website as well as promotional and/or educational purposes in print or via the internet.

_____ I understand that WJNS summer tuition is based on a seven-week enrollment and tuition is not prorated. (*June 3, 2024 - July 19, 2024)

_____ If I choose to withdraw my child from the program, a written notification (via letter or email) is required. Application/Activity fees are non- refundable. Summer tuition will be refunded for withdraws as follows:

- 75% through May 3rd
- 25% through May 24th
- 50% through May 17th
- **No refund after June 7**

_____ My child, _____ has permission to participate in all activities while at WJNS J Camp.

I understand that the WJNS J Camp Administrative staff and camp counselors/junior leaders will supervise campers to the best of their ability. In the event of an unforeseen incident/accident, I hereby WAIVE the WJNS J Camp Administrative staff and counselors from any responsibility.

Parent Signature: _____ Date: _____

How did you hear about us (please check one): Friends Family Website Other: _____

Referred By: _____

AUTHORIZATION FOR PICKUP & EMERGENCY CONTACT INFORMATION FOR

NAME OF CHILD: _____

PARENTS' INFORMATION:

Mother's Name	Home Phone	Cell Phone	Email
Father's Name	Home Phone	Cell Phone	Email

AUTHORIZED PICK UP:

Name	Home Phone	Cell Phone	Home Address	Relationship to Child

EMERGENCY CONTACTS:

Name	Home Phone	Cell Phone	Home Address	Relationship to Child

I will contact the school office staff via email or phone when authorizing someone else who is not on the list to pick up my child. A picture ID of persons picking up my child will be required.

Parent/Guardian (Print Name)

Parent/ Guardian Signature

Date

MEDICAL INFORMATION:

Pediatrician's Name & Phone Number: _____

Medical Insurance: _____ Policy #: _____

Does your child require special accommodations in regard to activity and/or diet? Yes ___ No ___

If yes, please explain: _____

Is there any additional information you would like to tell us about your child?

ALLERGIES:

Specialist's Name & Phone Number: _____

Description of Allergy: _____

Describe what signs/symptoms look like: _____

Describe known triggers: _____

Describe treatment & side effects: _____

When to call parent/health provider regarding symptoms or failure to respond to treatment:

When to consider when what conditions require urgent care or reassessment:

AUTHORIZATION TO ADMINISTER MEDICATION:

Name of Medication(s): _____

When to Administer: _____

Dosage: _____

I, the undersigned, request and authorize the personnel of Waolani Judd Nazarene School to administer medication as prescribed by my child's physician. I request and authorize the release of health information between the school, the prescribing physician, and the pharmacist pertinent to my child's condition. I understand that a new request is needed should there be any change to the medication order.

Parent Signature: _____ Date: _____