

Holy Spirit Summer Squad!

The first day of camp is June 10 and will end on August 16.



Hours:
8 a.m.-5:30 p.m.
Monday-Friday

A summer day camp experience for children entering grades K-5 during the 2024-2025 school year at Holy Spirit.

WEDNESDAY IS FIELD TRIP DAY!



A non-refundable \$65 family registration fee will be applied to your Blackbaud statement.

of children Daily Rate

1	\$55
2	\$50
3+	\$45

Director: Miranda Mader ~ extendeddays@holy-spirit.org



Holy Spirit Summer Squad Parent Contract - Summer 2024

Child's Name _____

Grade _____

Parent(s)/Guardian(s) Name(s) _____

DAILY CARE: 8 A.M.–5:30 P.M.

***Field trips will be on Wednesdays**

JUNE

S	M	T	W	Th	F	S
	10	11	12	13	14	X
X	17	18	19	20	21	X
X	24	25	26	27	28	X
X						

JULY (Closed July 3–5)

S	M	T	W	Th	F	S
	1	2	X	X	X	X
X	8	9	10	11	12	X
X	15	16	17	18	19	X
X	22	23	24	25	26	X
X	29	30	31			

AUGUST

S	M	T	W	Th	F	S
				1	2	X
X	5	6	7	8	9	X
X	12	13	14	15	16	

Please indicate, by circling the dates, when your child will be attending Summer Squad.

I agree to pay for the days my child is registered for Summer Squad unless Holy Spirit is not in session.

This includes absences to due illness, etc. I, the undersigned, request admission to the Summer Squad program for the above child(ren) and hereby agree to its tuition and procedures. Further, I agree to give two weeks' notice if I remove my child from the program. In accordance with school policy, I understand that failure to pay tuition on a timely basis will result in removal of my child from the Summer Squad program.

ALL PAYMENTS WILL OCCUR THROUGH BLACKBAUD

Registration is due Monday, Apr. 15, 2024

Any late registrations will incur an additional \$15 registration fee (\$65+\$15=\$80)

Parent Signature

Date

Holy Spirit Catholic School
SUMMER SQUAD 2024
PARENTAL/GUARDIAN CONSENT FORM AND
LIABILITY WAIVER

Student/Participant's name: _____

Date of birth: _____

Parent/Guardian's name(s): _____

Home address: _____

Home/Cell phone: _____ Business phone: _____

Home/Cell phone: _____ Business phone: _____

I, _____ grant permission for my child, _____,
Printed Parent or guardian's name Printed Child's name

to participate in this school summer program. This program will take place under the guidance and direction of school employees and/or volunteers.

I understand and agree that as parent and/or legal guardian, I remain legally responsible for any personal actions taken by the above-named minor ("participant"). I understand that my child is required to comply with the Code of Conduct provided by the school while participating in this program. I understand and agree that if my child violates the Code of Conduct, he/she may be required to be sent home at my expense.

I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend Holy Spirit Catholic School, its officers, directors, employees, coaches, and agents, and the Archdiocese of Saint Paul and Minneapolis, its employees and agents, chaperones, or representatives associated with the event and activities (hereinafter "Releasees"), from any claims, including but not limited to all claims relating to communicable disease, arising from or in connection with my child attending the program or in connection with any illness or injury (including death) or cost of medical treatment in connection therewith, and I agree to compensate Releasees for reasonable attorney's fees and expenses which may incur in any action brought against them as a result of such injury or damage.

Signature: _____

Date: _____

MEDICAL MATTERS: I hereby warrant that to the best of my knowledge; my child is in good health, and I assume all responsibility for the health of my child.

(Of the following statements pertaining to medical matters, sign only those that are applicable.)

Emergency Medical Treatment: In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above numbers, contact:

Name & relationship (emergency contact): _____

Phone: _____

Family doctor: _____ Phone: _____

Family Health Plan Carrier: _____ Policy ID #: _____

Signature: _____ Date: _____

Other Medical Treatment: In the event it comes to the attention of the school, its officers, directors and agents, and the Archdiocese of Saint Paul and Minneapolis, chaperones, or representatives associated with the program, that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called as soon as it is reasonably possible.

****Sign only if you want a call as soon as reasonably possible.***

Signature: _____ Date: _____

Medications:

My child is taking medication at present. My child will bring all such medications necessary and such medications will be well-labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage, will be provided.

****Sign only if child is taking medication and bringing.***

Signature: _____ Date: _____

No medication of any type, whether prescription or non-prescription, may be administered to my child unless the situation is life-threatening and emergency treatment is required.

****Sign only if child is NOT taking medication.***

Signature: _____ Date: _____

I hereby grant permission for non-prescription medication (i.e., non-aspirin products such as acetaminophen or ibuprofen, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

****Sign only if you grant permission for non-prescription medication to be given.***

Signature: _____ Date: _____

Specific Medical Information: The school will take reasonable care to see that the following information will be held in confidence.

Allergic reactions (medications, foods, plants, insects, etc.): _____

Immunizations: Date of last tetanus/diphtheria immunization: _____

Does your child have a medically prescribed diet? _____

Does your child have any physical limitations? _____

Has your child recently been exposed to contagious disease or conditions, such as mumps, measles, chicken pox, etc.? yes/no If so, list date and disease or condition: _____

You should be aware of these special medical conditions of my child: _____

As Parent or Guardian, I agree to all the above stated considerations and conditions.

Signature: _____ Date: _____

T-Shirt Order Form

We will be getting new t-shirts this year! Please select the size your child(ren) will need.

The following shirt sizes are available:

Youth: X-Small Small Medium Large

Adult: Small Medium Large

Name_____ Shirt size_____

Name_____ Shirt size_____

Name_____ Shirt size_____

