CAMP CHABAD

2204 CEDARVIEW DRIVE, BEACHWOOD, OH 44122
MRS. JILL WEISZNER (216) 402-4877
Email: Jiris770@aol.com Fax: 216-382-0008
or text Jill at (216) 402-4877

	CHILD 1	CHILD 2	CHILD 3
FIRST NAME			
LAST NAME			
DATE OF BIRTH			
AGE AS OF 06/24/24			
GRADE AS OF 08/19/24			
MALE/FEMALE			
FULL SESSION OR SPECIFY WEEKS	FULL: YES NO 1 2 3 4 5 6 7 8 (CIRCLE)	FULL: YES NO 1 2 3 4 5 6 7 8 (CIRCLE)	FULL: YES NO 1 2 3 4 5 6 7 8 (CIRCLE)

Family Name: _____

Father's Name: _____

Mother's Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____

Father's Business #: _____

Mother's Business #: _____

Person to call in case of Emergency:

Name: _____

Emergency #: _____

Relationship: _____

Family Doctor: _____

Phone: _____

Family Dentist: _____

Phone: _____

Special Health or Allergy Problems:
If yes, give details: _____

DATES: JUNE 24 - AUGUST 16, 2024
TIME: 9:30 am – 3:30 pm, Friday 9:30 am – 1:45 pm
PLACE: All campers ages 4 - 12 meet at:
THE WAXMAN CHABAD CENTER
2479 SOUTH GREEN ROAD, BEACHWOOD, OHIO 44122
PRICE: $770 for 8 weeks or $125 per week
(plus weekly trip cost) total 8 week summer trips cost approx. $88
LUNCH: WE PROVIDE FREE LUNCH TO ALL CAMPERS AND COUNSELORS REGARDLESS OF INCOME

Please Read this Agreement and Sign Below:

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for the administration of treatment deemed necessary by our family physician or by any other licensed physician in the event the designated family physician is not available. This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists concurring in the necessity for each surgery are obtained prior to the performance of each surgery.

Signed: _____ Dated: _____
Parent/Guardian

E-mail Address: _____

This institution is an equal opportunity provider