Autism Family Retreat Camp
August 24-28th, 2009

Mail to: Dr. Sheryl Wagner

8513 NE Hazel Dell Ave. Suite 203
Vancouver, WA 98686

Registration Form

Name of parent ____ age________

Name of second parent ____ age ________

Name of child ____ age ________

Developmental problems/diagnosis____

Food or other allergies ____

Child 2 ____ age ________

Developmental problems/diagnosis____

Food or other allergies ____

Child 3 ____ age ________

Developmental problems/diagnosis____

Food or other allergies ____

(attach additional sheet for other family members)

Please list therapies for autism/developmental delays which you have tried or are currently doing:

Please list any special considerations or amenities your child needs during the camp week:

____

____

____

Parent name ____

email ____

Mailing address ____

____

Phone numbers ____

____

Emergency contact NAME PHONE

____

Payment information

Camp costs: $525 for first parent/child pair and $200 for each additional family member

Number of family members attending (at least one parent must attend): __________

Total cost:	First parent/child pair	$525
	other parent or child ($200)	_____
	additional child ($200)	_____
	additional child ($200)	_____
	additional children ($150 ea.)	_____
	TOTAL	_____

(NOTE: ONE FAMILY PER FORM)

Check / Credit card (circle one)

Non-refundable deposit: $100 per person

Pay now: **deposits only / full price** (circle one) Total this payment: __________

MC/VISA (circle one) Name on card _________________________________

Card number ____________________________________ Exp. date ________

Signature ____