**Youth Career Camp Inc.**
**Program Registration Packet**
## For Summer – 2019 Ages 18-21

Registration fee must be submitted with this packet. ***Final program fee must be paid before May 2, 2019***.
*Packets submitted on, or after May 2nd may not be accepted.*

**Date_____ Payment:_____ □Cash □Check □Card □Online(Confirmation No._____)**

## YOUR INFORMATION

Last Name: _____ Middle Initial: ____ First Name: _____

Social Security Number: _____ Date of Birth:_____ Gender:____ Age_____

Drivers License / Permit No:_____ State: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Currently Employed: YES / NO

Are You A High School Graduate? YES [Year:_____] / NO
Currently Attending High School At: _____
Last Attended High School At: _____

Place a Check Mark In The Box Next To The Type of School You Wish To Attend

☐ GED ☐ Technical College ☐ Community College ☐ University ☐ None

What type of degree are you currently interested in? _____

List 3 things you would like to do in order to make a living now, and, or in the future:

1._____
2._____
3._____

Are you interested in a job shadow opportunity after this program? YES / NO (circle one)
If yes, what type of job shadowing are you interested in? _____

Please list your recreational interests / hobbies:

_____
_____

## PERSONAL AGREEMENT AND LIABILITY RELEASE

I, _____ Agree to attend YCC/YEP 2019 and to participate
*(Enter your full name)*
in all training, activities, field trips, and fundraising events as outlined in YCC-YEP 2019 program agendas. I understand that the program registration fee is not refundable under any circumstance. **I agree to pay $100 on or before May 1, 2019.** I understand and agree that if I do not make the final and full $100 payment by May 1st I may be released from YCC/YEP 2019. I understand that **to receive a refund of any amount of my $100 payment, I must withdraw from YCC/YEP 2019 on or before May 1st.** If I withdraw or if I am released from YCC/YEP 2019 for any reason, on or after **May 2nd, I will receive no refund** of any amount.
I give permission to Youth Career Camp Inc. Directors, and staff to act on my behalf, to request or obtain any medical treatment for me, which they consider to be appropriate or necessary, in the event I am injured or, if I become ill during field trips and any other activities associated with YCC/YEP 2019. I further authorize emergency medical technicians or other health care providers to provide medical treatment and care as deemed necessary for my health, safety and well-being if I am unable to do so. I hereby release Youth Career Camp Inc. from any claims which I might otherwise have against, it's Directors, or Staff, for authorizing such medical care or treatment for me under emergency conditions as warranted under the circumstances. I understand and agree that I will be financially responsible for all charges incurred in connection with any medical treatment while attending YCC/YEP 2019.

Please place **YOUR INITIALS** in the blocks next to the appropriate statement.

☐ **I have Medical Insurance.**

Provider: _____

Address: _____

Phone #: _____ Policy #: _____

Group #: _____ Dr's Name:_____

☐ **I do not have health insurance and I am personally responsible for any expenses resulting from medical treatment, or Dr. visits at any time during YCC/YEP 2019.**

☐ **I have the following allergies, physical, and/or medical limitations** (Please be specific and attach appropriate medical release**):**

_____

_____

☐ **I have NO allergies, physical, and/or medical limitations.**

Please place **YOUR INITIALS** in the blocks next to the appropriate statement

☐ **I currently takes the following medications:**

**Name of the Medication**: _____
Dosage required: _____ Time/Frequency taken: _____
How is medication administered? **(Circle One)** by Mouth, Inhaler, Cream, Shot,
Other: _____
**Name of Medication**: _____
Dosage required: _____ Time/Frequency taken: _____
How is medication administered? **(Circle One)** by Mouth, Inhaler, Cream, Shot,
Other: _____
Prescribing Physician: _____ Phone:_____

☐ **I take no medications**

## NEXT OF KIN INFORMATION

Name: _____ Relationship:_____
Home Phone: (_____) - _____-_____ Cell Phone(_____) _____-_____
Work Phone: (_____) - _____-_____ E-mail_____
Address**:** If different from yours: _____

Name: _____ Relationship:_____
Home Phone: (_____) - _____-_____ Cell Phone(_____) _____-_____
Work Phone: (_____) - _____-_____ E-mail_____
Address**:** If different from your: _____

**Emergency Contact Person**: _____ Relationship: _____
Home Phone: (_____) - _____-_____ Cell Phone _____
Work Phone: (_____)- _____-_____

Your Signature: _____

Seal for Notary:

Signature of Notary: _____

My commission expires: _____