Youth Career Camp Inc.
Program Registration Packet
For Summer Camp – 2020 Ages 14-17

Registration fee must be submitted with this packet. ***Final program fee must be paid before May 22, 2020***.
Packets submitted on or after May 22nd may not be accepted.

Date____________ Payment:________ □Cash □Check □Card □Online(Confirmation No.________________)

PARTICIPANT'S 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: ______________

Phone: ___________________________ Cell Phone: ______________________________ TShirt Size:_____

Email: ____ Currently Employed: YES / NO

High School Graduate? YES [Year:______________] / NO
Currently Attending High School At: ____
Last Attended High School At: ____

Place Check 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? ____

What are your plans after receiving your high school diploma?

____

____

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 job shadowing at the end of this program? YES / NO (circle one)
If yes, what type of job shadowing are you interested in? ____

Please list your interests or hobbies: ____

____

PARENTAL AGREEMENT AND PERMISSION SECTION

I, ________________________________ the legal parent/guardian of ____________________________________
(Enter participant's full name)
authorize him/her to attend and participate in all YCC-2020 activities including field trips as outlined in program itinerary and agendas. I understand that the registration fee submitted with this form is not refundable under any circumstances.

I agree to pay $100 on or before May 16, 2020. I understand and agree that if I do not make the final and full $100 payment by May 16th my child may be released from YCC- 2020. I understand that **to receive a refund of any amount of my $100 payment, I must withdraw him/her from YCC- 2020 on or before May 16th.** If I withdraw him/her, or if he/she is released from YCC-2020 for any reason on or after **May 17, I will receive no refund** of any amount.

I give permission to Youth Career Camp Inc. Directors, and it's staff to act on my behalf, to request or obtain any medical treatment for my child, which they consider to be appropriate or necessary, in the event my child is injured or, if my child becomes ill during field trips and any other activities associated with YCC-2020. I further authorize emergency medical technicians or other health care providers to provide medical treatment and care as deemed necessary for my child's 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, them, it's Directors, or Staff, for authorizing such medical care or treatment for my child 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-2020.

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

☐ **I have Medical Insurance for this participating child.**

Provider: ____

Address: ____

Phone #: ______________________ Policy #: ______________________

Group #: ______________________ Dr's Name: ______________________

☐ **I do not have insurance for this participating child, and I am responsible for any expenses resulting from medical treatment, or Dr. visits at any time during YCC-2020.**

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

____

____

☐ **My child HAS NO allergies, physical and/or medical limitations.**

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

[ ] **My child 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: ______________________

[ ] **My Child does not take medications**

PARENTS/GUARDIANS INFORMATION

Name: ______________________ Relationship: ______________________

Home Phone: (______) - ________-________ Cell Phone(______) __________-__________

Work Phone: (______) - ________-________ E-mail ______________________

Address**:** If different from Youth: ______________________

Name: ______________________ Relationship: ______________________

Home Phone: (______) - ________-________ Cell Phone(______) __________-__________

Work Phone: (______) - ________-________ E-mail ______________________

Address**:** If different from Youth: ______________________

Emergency Contact Person: ______________________ Relationship: ______________________

Home Phone: (______) - ________-________ Cell Phone ______________________

Work Phone: (______)- ________-________

Signature of parent/guardian completing these forms: ______________________

Seal for Notary:

Signature of Notary: ______________________

My commission expires: ______________________