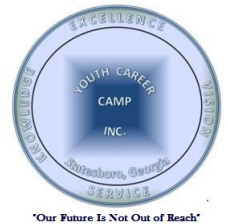




**Youth Career Camp Inc.
Program Registration Packet
For Summer Camp – 2018**



*Parents or legal guardians of participants must submit this completed registration packet **with payment for registration before March 30, 2018.** Packets/payments submitted after this date 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 _____

Grade (Next school year): _____ School (Next school year): _____

Middle School (For Current 8th Graders) _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Participant's Cell Phone: _____

Participant's Email: _____ Currently Employed: YES ☐ NO ☐

What type of post-secondary education do you wish to pursue after high school? (circle one)

☐University ☐College ☐Community College ☐Technical School ☐Other ☐None

If you wish to further your education after high school, how do you plan to pay for it?

If you do not wish to further your education after high school, what are your plans after high school?

Name 3 career fields you interested in pursuing. List your most desired choice first:

1. _____
2. _____
3. _____

Are you interested in job shadowing at the end of this program? YES ☐ NO ☐ (circle one)

If yes, in which one of the above career fields: _____

Please list your interests or hobbies:

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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 Youth Career Camp activities including field trips as outlined on program itinerary and agendas. I understand that the registration fee is not refundable under any circumstance. **I agree to pay \$100 for tuition on or before April 13, 2018**, and that I may choose to make partial payments of this tuition, making the final and full payment by April 13, 2018. I agree that if I do not make the final and full payment of tuition by April 13, 2018, my child released from this program. I understand that **to receive a refund of any amount my tuition, I must withdraw my son/daughter from this program on or before April 13, 2018**. I agree that if my child is withdrawn or released from this program for any reason on or after **April 14, 2018 I will receive no refund** of any kind.

I give Youth Career Camp Inc. Directors and staff permission to act on my behalf to request/obtain any medical treatment which they consider to be appropriate or necessary, in the event my child is injured or becomes ill during field trips and any other activities associated with this program. I further authorize emergency medical technicians or other health care providers to provide medical treatment and care as deemed necessary for the health, safety and well-being of my child. I hereby release any claims which I might otherwise have against Youth Career Camp Inc., the Director, 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 such medical treatment.

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

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

Provider: _____

Address: _____

Phone Number: _____

Policy Number: _____ Group Number: _____

Child's Social Security Number: _____

☐ **I do not have insurance for this participating child, and I am responsible for any expenses resulting from medical treatment, or Dr.'s visits any time during this program.**

☐ **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.**

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

☐ **My child currently takes the following medications:**

Name of the Medication: _____

Dosage: _____ Time medication should be given: _____

How is medication administered? (**Circle One**) by Mouth, Inhaler, Cream, Shot,

Other: _____

Name of Medication: _____

Dosage: _____ Time medication should be given: _____

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: _____