



**Making A Difference For
At-Risk Minority Youth In Collier County**

FALL YOUTH SESSIONS-11/02/21-01/27/22

Youth

First _____ Middle _____ Last _____ Gender: Male__ Female__
School Name _____ Grade _____ Birth Date ___/___/___ Age (as of Nov. 01, 2021) _____
Street Address _____
Town/City _____ State _____ Zip Code _____ Youth Home Phone _____

Parent/Guardian- Contact Information

Parent/Guardian #1

First _____ Last _____ Ms. Mrs. Mr. Other _____
Street Address _____
Town/City _____ State _____ Zip Code _____ Home Phone _____ Daytime Phone _____
Cell Phone _____ Fax _____ Email _____
Occupation _____ Employer _____
Child lives with: _____

Parent/Guardian #2

First _____ Last _____ Ms. Mrs. Mr. Other _____
Street Address _____
Town/City _____ State _____ Zip Code _____ Home Phone _____ Daytime Phone _____
Cell Phone _____ Fax _____ Email _____
Occupation _____ Employer _____
Child lives with: _____

Emergency Contact Information- Alternate Pickup/Release

Emergency Contact #1

First Name _____ Last Name _____ Home Phone _____

Cell Phone _____ Email _____ Relation to Child _____

Emergency Contact #2

First Name _____ Last Name _____ Home Phone _____

Cell Phone _____ Email _____ Relation to Child _____

Please list those people, in addition to parents/guardians, who are permitted to pick up your child

1: _____ 2: _____ 3: _____

Medical Release Information

Insurance Information

Policy Number _____ Name of Health Provider _____

Primary Physician _____

Address _____

Phone _____ Hospital Preference _____

Please list any medical problems, including any requiring maintenance medication (i.e. Diabetic, Asthma, Seizures).

Medical Problem	Required Treatment	Should Paramedic be called?
_____	_____	Yes/No
_____	_____	Yes/No
_____	_____	Yes/No

Is your youth presently being treated for an injury, sickness, or taking any form of medication for any reason?

Yes _____ No _____ If yes, explain: _____

Is your child allergic to any type of food or medication?

Yes _____ No _____ If yes, explain: _____

Does your child require a special diet?

Yes _____ No _____ If yes, explain: _____

The purpose of the above listed information is to ensure that medical personnel have details of any medical problem which may interfere with or alter treatment.

I understand that I will be notified in the case of a medical emergency involving my child. In the event that I cannot be reached, I authorize the calling of a doctor and the providing of necessary medical services in the event my child is injured or becomes ill.

Parent's/Guardian's Initials _____

I understand that the Trinity Life Foundation will not be responsible for the medical expenses incurred, but that such expenses will be my responsibility as parent/guardian

Parent's/Guardian's Initials _____

Please circle how you heard about the Trinity Life Foundation.

After School Program Website School Word of Mouth Flyer Other _____

Terms of Agreement

Photo Release

I hereby give my permission for my child to be photographed during the workshop sessions. I understand the photos will be used to keep a journal of activities to share during power point presentation and/or reports to our donors and for promotional purposes including flyers, brochures, newspaper and on the internet. I understand that although my child's photograph may be used for advertising, his or her identity will not be disclosed, I do not expect compensation and that all photos are the property of the Trinity Life Foundation.

Parent's/Guardian's Initials _____

Transportation Release

I hereby give permission for the transportation of my child for official Fall Youth Sessions activities by modes of transportation agreed to by the TLF organizers.

Parent's/Guardian's Initials _____

The Trinity Life Foundation and its co-organizers are not responsible for lost or damaged personal property. All scheduled events are subject to change. I understand that no fees will be refunded or transferred unless a child is unable to participate due to an accident or illness per physician orders. Students' photos and quotes may be used for publicity purposes. In case of an emergency, and if a family member cannot be reached, I hereby authorize my child to be treated by Certified Emergency Personnel (i.e. EMT, First Responder, and/or Physician).

I understand, acknowledge and agree that Trinity Life Foundation, will provide for reasonable supervision of students within its care and control. The supervision will be consistent with the ages of the students. However, the Trinity Life Foundation Board is not an insurer of the safety of the students nor can it supervise all movements of all students at all times. In addition, there are certain risks inherent in travel and at the destination. I further understand that an employee or volunteer has no personal liability unless he or she has acted recklessly, wantonly, or intentionally to injure my child.

Parent/Guardian Signature: _____ Date _____

Printed Name of Parent/Guardian: _____