Application
Mt. Zion Baptist Church
Summer Youth Academy for Boys 2019
June 3, 2019 -- July 11`, 2019
We will be closed July 3rd and 4th

Student Information

Last Name _____ First Name _____ MI _____

Street Address _____ City _____ Zip Code _____

Home Phone _____ Emergency Phone _____ School Attended _____ ***Grade next school year*** _____

Known Illnesses _____ **T-Shirt Size**

Parent/Guardian Information

Last Name _____ First Name _____ MI _____

Street Address _____ City _____ Zip Code _____

Home Phone _____ Work/Emergency/Contact Phone _____ Other _____

If you do not want your child to be PHOTOGRAPHED, please sign here. _____

Application and Tuition of $175.00 is due by ***May 31, 2019***

Swimming Classes are separate $35.00

Make Checks payable to Mt. Zion Baptist Church Youth Academy.
All parts of the application must be filled out completely
All applications must be turned in at the Mt. Zion Baptist Church
901 Westover Blvd.
Albany, GA 31701
Office Phone 434 0550

EMERGENCY CONTACT FORM

Participant's Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

Address: _____

Number(s) to call in emergency: _____

Parent/Guardian place of employment: _____

Address: _____

Work number: _____ Family Doctor: _____ Phone: _____

Address: _____

***Emergency Medical Treatment*:** In the event of an emergency, I hereby give permission to transport my child to a hospital by car or ambulance for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, transport my child to _____.

***Medications*:** My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage is as follows:

Check all that apply:

- ☐ No medication of any type whether prescription or nonprescription may be administered to my child.
- ☐ No medication of any type whether prescription or nonprescription may be administered to my child unless the situation is life-threatening and emergency treatment is required.
- ☐ I hereby grant permission for nonprescription medication to be given to my child if they become ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea such as aspirin, throat lozenges, and cough syrup.

Special Medical Information:

Allergic reactions (medications, foods, plants, insects, etc.): _____

Vaccinations/Shots are up to date: Yes _____ No _____

Most recent date of Tetanus Shot: _____

You should be aware of these known medical conditions of my child. _____

_____

Signature _____ Date _____

*Email Address*_____

Please make sure that all information is current.