DOING THE MOST GOOD

THE SALVATION ARMY COMMUNITY YOUTH CENTER

TODAY'S DATE_____

Youth's Name_____ _____
First Middle Last

Home Address _____ _____

City_____ **Zip** _____

Phone (_____)_____ **Alt Phone** (_____)_____

Age _____ **Birth date** _____/_____/_____ **Sex** *(circle)* M F

Country of Origin:_____

Ethnic Identity *(circle)* African Asian or Pacific Islander Hispanic Native-American Caucasian African-American Other_____

CHILD LIVES WITH: *(Circle one)*

Both Parents Mother Father Aunt/Uncle Sister/Brother Grandparent

Other _____

Name of School _____ **Grade** _____

Teacher_____

Person(s) authorized to take your child from the facility:

_____ _____
Name: Phone Number:

_____ _____
Name: Phone Number:

MEDICAL RELEASE AND HEALTH HISTORY INFORMATION:

*In any event of an accident or sudden illness, every attempt shall be made to contact the parent / guardian **before** seeking emergency treatment.*

If we are unable to contact responsible parties, important health information about the child and the legal permission needed to provide medical treatment is necessary. The following pre-consent form enables health care professional to treat your child for minor emergencies.

I, _____parent/legal guardian of_____
Print Name parent/guardian *Child's Name*

authorize healthcare personnel to treat my child in an emergency while in the care of The Salvation Army.

HEALTH HISTORY: (give approx. dates)
____ Frequent ear infections
____ Heart defect/disease
____ Convulsions
____ Diabetes
____ Bleeding. clotting disorders
____ Hypertension
____ Mononucleosis
____ Psychiatric treatment
____ Strep throat

Diseases:
____ Chicken Pox
____ German Measles
____ Mumps
____ Lead Poisoning
____ Sickle Cell

Allergies: *(dates not needed)*
____ Hay Fever
____ Poison Ivy, Etc.
____ Insect Stings
____ Penicillin
____ Other Drugs
____ Asthma
____Other *(specify)*

***In the event of a medical emergency, I:** *(Please Check One)*
_____give my permission for my child to be treated medically
_____**Under NO circumstances** do I want my child to be treated medically

In case of emergency contact 1** ***(Please print)

_____**Phone**_____

In case of emergency contact 2** ***(Please print)

_____**Phone**_____

Preferred Physician_____**Phone**_____

Preferred Hospital/Medical facility_____

Medicines your child is taking now: _____

Allergies, if any, including medication:_____

Other information:_____

Please provide up-to-date Immunization History

Date of last tetanus booster: _____/_____/_____

Medical Insurance carrier: _____

Member's Name: _____

PHOTO RELEASE:

I grant permission for The Salvation Army to use photographs of my child

_____

(Child's name here) **or any likeness thereof for the purposes of publications, public testimonials, publicity, and community relations purposes.**

To obtain from photo, video, interview or other documenting medium the subjects right to use their portraits, actions and statements in Salvation Army publications, promotions, and/or advertising, I hereby irrevocably grant to The Salvation Army the absolute right and permission to copyright and/or publish or use photographic portraits of me, or in which I may be included in whole or in part, or composite or distorted in character or form, in conjunction with my name or a fictitious name, or reproductions thereof in color or otherwise, made through any media, for art, advertising or any other lawful purpose whatsoever. I also grant The Salvation Army the same right and permission to use any statements or testimonials made by me.

I,_____have read this application and all attachments. I understand the rules of The Salvation Army Community Youth Center Program and have explained them to my child. I request that my child be admitted into membership. I agree that The Salvation Army will not be responsible for any accident to the child while on the premises or while engaged in any of its activities