

YEOH YOUTH EXPRESSION OF HEALTH VI WORKSHOP APPLICATION 2008

APPLICANT INFORMATION (PLEASE MAKE SURE ALL AREAS ARE FILLED OUT)

Name:

Date of birth:	SSN: (required)	Phone:
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Current address:

City:	State:	ZIP Code:
School:	Church:	Hobby:

EMERGENCY CONTACT

Name of a relative :

Address:	Phone:
	Business:
	Cell:
City:	ZIP Code:
State:	
Name	Phone
Address	

Please list any medical conditions we should know about

REFERENCES

Name
Name

SIGNATURES

In case of sudden illness or an accident to the below named participant, requiring immediate treatment, while participating in YEOH Workshop I authorize the Primary Staff or Medical Staff to take such action as deemed appropriate to protect the health and physical well-being of my child. This authority extends to any physician(s) selected by the Primary Staff of YEOH. All efforts will be made to contact the parent(s) or guardians(s) in case of an emergency.

Signature of applicant:	Date:
Signature of Parent:	Date:

