



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

## Student Information

Last Name	First Name	MI	
Street Address	City	Zip Code	
Home Phone	Emergency Phone	School Attended	<i>Grade next school year</i>

Known Illnesses	<b>T-Shirt Size</b>
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### 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.*