

**Tomorrow’s Leaders Youth Mentoring Program**

**Summer Camp Application – Year 2024**

**Child Information:**

Child Full Name: Preferred Name:

Address:

 Street City State Zip Code

Date of Birth: /\_\_\_/ Age:

Race: □ Hispanic OR □ Non-Hispanic Gender: □Male □Female □Other

***If Applicable:***

Phone: ( ) Email Address:

**Parent Information:**

Parent Full Name: Preferred Name:

Address:

 Street City State Zip Code

Phone: ( ) Alternate Phone: ( )

Email Address:

***Name of Person(s) to Notify in Case of Emergency:***

**Emergency Contact Name #1**: Relationship:

Address:

 Street City State Zip Code

Phone (Home): \_ \_\_ \_\_-\_\_\_ \_\_-\_\_\_\_ \_\_ Phone (Cell): \_ \_\_ \_\_-\_\_\_ \_\_-\_\_\_\_ \_\_ Phone (Work): \_ \_\_ \_\_-\_\_\_ \_\_-\_\_\_\_ \_\_

**Emergency Contact Name #2**: Relationship:

Address:

 Street City State Zip Code

Phone (Home): \_ \_\_ \_\_-\_\_\_ \_\_-\_\_\_\_ \_\_ Phone (Cell): \_ \_\_ \_\_-\_\_\_ \_\_-\_\_\_\_ \_\_ Phone (Work): \_ \_\_ \_\_-\_\_\_ \_\_-\_\_\_\_ \_\_

***Medical Information:***

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ Phone (Work): \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_

Address: Suite:

Insurance Name: Policy Number:

Hospital Preference:

Please list any food or medicine allergies:

List current medications:

List any health concerns:

***By signing below, I give permission for my child to participate in Tomorrow’s Leaders, Summer Camp 2024. I understand activities in this will include curriculum study and field trips that may include swimming and water activities and recreational sporting. I give permission for TAP to transport my child and I authorization the share of medical information and treatment from qualified medical personnel for essential treatment of my child. I understand that in case of an emergency I will be contacted immediately.***

**Student Signature: Date:**

**Parent’s Signature: Date:**