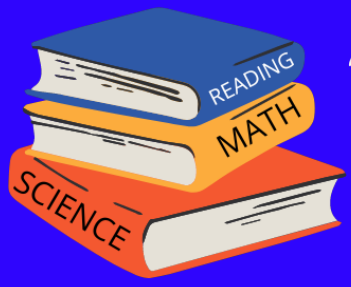


White Family Learning Center

EDUCATION . MENTORING . COUNSELING

www.whitefamilylearningcenter.org

DCC
607 E. Edgerton Street
Dunn, NC 28334
910-658-5350
sawsnead@yahoo.com

YOUTH APPLICATION

To be completed and placed on file prior to enrollment

(Mail Application To: PO Box 134, Dunn, NC 28335)

Application Date: _____/_____/_____ Date of Enrollment: _____/_____/_____

_____ _____

(Last) (First) (Mi) (Nickname)

Birthdate: _____ Ethnicity: _____ School: _____ Grade: _____

_____

Physical Address City Zip Code

_____

Mailing Address City Zip Code

INFORMATION ABOUT THE FAMILY

_____ Home Phone: _____-_____-_____

Father/Guardian's Name Alternate Phone: _____-_____-_____

_____

Physical Address City Zip Code

_____

Employer (if applicable) Business Phone

_____ Home Phone: _____-_____-_____

Mother/Guardian's Name Alternate Phone: _____-_____-_____

_____

Physical Address City Zip Code

_____

Employer (if applicable) Business Phone

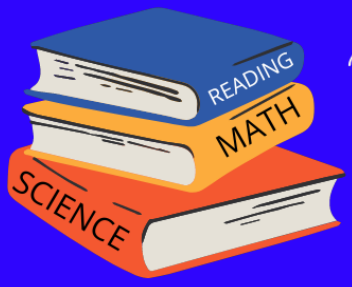
INFORMATION ABOUT YOUR CHILD

Does your child have any known allergies? No __ Yes__ Explain: _____

Does your child have any chronic illnesses/conditions? No __ Yes __Explain: _____

Please give any information concerning your child which will be helpful in their experience in group setting: _____

_____



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EMERGENCY INFORMATION

If father, mother or guardian can't be reached, call:

Name and Relationship	Home Phone	Alternate Phone
_____	_____-_____-_____	_____-_____-_____
_____	_____-_____-_____	_____-_____-_____

Please list any names of persons to whom the child can be released: _____

_____

_____

_____

EMERGENCY CARE INFORMATION

Doctor Name: _____ Phone Number: _____-_____-_____

Dentist Name: _____ Phone Number: _____-_____-_____

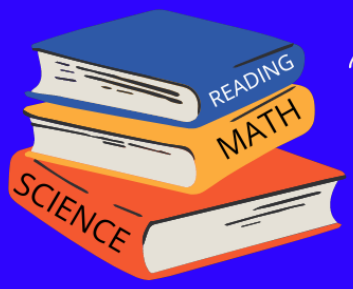
Hospital Preference: _____ Phone Number: _____-_____-_____

Insurance Carrier: _____ I.D. #: _____

I agree that WFLC may authorize the physician of their choice to provide emergency care in the event that neither I nor the family physician can be reached immediately.

_____

Signature of Parent/Guardian Date



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All information on this document shall be kept confidential. The following information is requested for our records and for the funding our organization receives. All information provided on this form must be updated every year.

Head of Household: _____
Last Name First Name Gender

Spouse/Partner: _____
(If married) Last Name First Name Gender

Total Number Living In Household: _____

HOUSEHOLD TYPE

___ Both Parents ___ Single Parent ___Guardian

___ Foster Parent (1) ___ Foster Parent (2) ___ Group Home

REFERRING ORGANIZATION

___ Parent/Guardian/Friend ___Juvenile Services

___ Department of Social Services ___ Adult Court

___NC Probation Office ___ Harnett County Sheriff's Department

___ Cooperative Extension ___ Harnett County Job Links

___ Police Department
Name of Department: _____

___School
Name of School: _____

___ Other (please list): _____

_____

ASSISTANCE

Check all that apply:

EDUCATION

___ MATH

___ SCIENCE

___ READING

COUNSELING

___SUPPORT GROUP

___ MENTAL HEALTH

MENTORING

___SUBSTANCE ABUSE

___ GRIEF SUPPORT

___ AT RISK

___ JUVENILE

___ BUILDNG CHARACTER

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MEDICAL RELEASE

This form is to be filled out completely and filed with WFLC before the youth can participate in any activities or go on any trips.

MEDICAL HISTORY

Is there a known history of:

A. Birth Deformities? Yes ___ No ___
B. Known past illness of more than one week's duration? Yes ___ No ___
C. Medical conditions currently under treatment? Yes ___ No ___
D. Fractures or other disability? Yes ___ No ___
E. Any permanent deformity or disability? Yes ___ No ___
F. Allergy (drugs, food, clothing etc.)? Yes ___ No ___
G. Mental disorder or convulsions? Yes ___ No ___
H. Currently taking medications? Yes ___ No ___

If any above question is answered yes please explain in detail: _____

_____

_____

_____

_____

MEDICAL RELEASE FORM

I am the legal parent/guardian of the youth applying to WFLC for services and/or support and I have legal custody and control of the youth and I do hereby grant the WFLC Director, Staff, Volunteers and/or Coaches permission to seek treatment for my child at a hospital or qualified physician in the case of an accident or injury for medical treatment. I give the WFLC Director, Staff, Volunteers and/or Coaches the authority to make emergency medical decisions in my absence and I know that they will contact me at the earliest time possible and notify me of emergency concerning my child. I further agree for my child to be transported to any medical facility for emergency medical treatment.

_____ DOB: _____/_____/_____
Name of Youth/Child

_____ Date: _____/_____/____
Signature of Legal Parent/Guardian

_____
Witness