

**THE EPISCOPAL URBAN CAUCUS  
YOUTH ASSEMBLY PARTICIPATION FORM**

Please complete and mail this form with registration fee to:

The Episcopal Urban Caucus  
P.O. Box 21182  
Park West Station  
New York, New York 10025

**To ensure participation and the EUC hotel rate, please note that registration and  
payment are due by February 6, 2012**

PLEASE LIST ALL MEDICATIONS

**PLEASE PRINT**

**Youth Participant's Name** \_\_\_\_\_

**Date of Birth** \_\_\_/\_\_\_/\_\_\_      **Sex**   M   F      **Grade in School 2011-2012** \_\_\_\_\_

**Address** \_\_\_\_\_

**City:** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Parent/Guardian/Next of Kin** \_\_\_\_\_

**Congregation and City** \_\_\_\_\_

**I can be reached at:** \_\_\_\_\_

**Daytime Phone** \_\_\_\_\_ **Nighttime Phone** \_\_\_\_\_

**Emergency Phone** \_\_\_\_\_ **Cell Phone** \_\_\_\_\_

**Other contact Name, Relationship** \_\_\_\_\_

**Name of Insurance and Policy Number** \_\_\_\_\_

**Any chronic conditions, food allergies, Other:** \_\_\_\_\_

**Medication:** \_\_\_\_\_

**Amount enclosed:** \_\_\_\_\_ **Dosage** \_\_\_\_\_

**Specific times taken each day** \_\_\_\_\_

**Reason for taking:** \_\_\_\_\_

**Additional medications:** \_\_\_\_\_

**Date of last tetanus shot** \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Physician's Phone Number: \_\_\_\_\_

Please make sure you have listed all medications (including over the counter or non-prescription drugs). All medications must be in the original container that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage and frequency of administration.

- ❖ I authorize the Urban Caucus adult youth chaperone in whose care the above minor has been entrusted to consent to any X-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment or hospital care, to be rendered to the minor under the general or specific supervision and on the advice of any physician or dentist under the provisions of the Medical Practice Act on the medical staff of a licensed hospital. I will be liable and agree to pay all costs and expenses incurred in connection with such medical and dental services rendered to the above-named minor pursuant to this authorization.
- ❖ I hereby give permission for the above named minor to ride in any vehicle designated by the adult in whose care the minor has been entrusted while attending and participating in the Episcopal Urban Caucus Assembly.
- ❖ I have read and understood the Community Covenant. I understand the above minor participant must respect and obey the instructions of the adults in charge and that tobacco, alcohol, illegal drugs, weapons, inappropriate sexual behavior or sexually explicit communications will not be permitted at the Assembly.
- ❖ I understand that the Episcopal Urban Caucus cannot be responsible for any valuables or electronic equipment brought to the Assembly without authorization.

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Authorization Signature of Parent/Guardian/Next of Kin

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Please print authorized name here

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