

# MINERVA SUMMER YOUTH PROGRAM

REGISTRATION & MEDICAL PERMISSION FORM  **2025**

Child's Name:	
Full Address:	
Email:	

<b>RESIDENT OF MINERVA/OLMSTEDVILLE :</b>	(Circle)	YES	NO
Child's Date of Birth	/ /	Age	
Child's Grade In September 2025		(Circle)	MALE FEMALE
Has your child been on the Youth Program Previously	(Circle)	YES	NO

IN CASE OF EMERGENCY CONTACT			
1.		Home Phone	
	Name	Relationship	Cell Phone
2.		Home Phone	
	Name	Relationship	Cell Phone

Does your child have any allergies / concerns	(Circle)	YES	NO
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If Yes, Please List:

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Does you child have any conditions Listed Below:	(Circle)	YES	NO
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If YES, please circle Conditions:

ASTHMA	CONVULSIONS/SEIZURES	HEMOPHILIA	KIDNEY DISEASE
HIGH BLOOD PRESSURE	CANCER/LEUKEMIA	DIABETES	HEART TROUBLE

Please List Medication(s):

(Must provide order from Doctor's office authorizing medication be given by Youth Program Health Officer)

NOTICE	
<b>IMMUNIZATIONS: ALL CHILDREN NOT ATTENDING NYS SCHOOL DISTRICTS MUST SUPPLY A CURRENT COPY OF THEIR IMMUNIZATION RECORDS. <u>NO CHILD WILL BE ALLOWED TO START THE PROGRAM WITHOUT THESE RECORDS.</u></b>	

Insurance Company:		Insurance Id #:	
Subscriber Name:		Group #:	
Subscriber DOB:			

**If you feel your child cannot adhere to our discipline policy or participate in all of our activities without modification, please contact Ashley Christian. We will be happy to meet with you and discuss your concerns so that we can ensure a fun and safe program for all. Please list any conditions, physical or behavioral, that may affect or limit full participation in the playing of strenuous physical games :**

I, \_\_\_\_\_, parent/guardian of \_\_\_\_\_ authorize the Minerva Youth Program to administer sunscreen. \* **Please note that parents/guardians are responsible for providing the sunscreen/bug spray that they would like their child to use. \***

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Parental authorization:**

This health history is correct in so far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me. I give the above registered child to attend the MYP, realizing there is not any medical insurance coverage. I hereby agree to assume any and all responsibility and liability in connection with this program as same pertains to the child listed herein. I further agree to save the Town of Minerva and its employees harmless from any claims and lawsuits in connection with the program. In the event I cannot be reached in an EMERGENCY, I hereby give permission to the medical provider selected by the MYP to evaluate, treat and/or hospitalize in an accredited hospital and to X-ray, treat, order injections, anesthesia or surgery for the child. I also hereby authorize the MYP to pull immunization records for the registrant.

Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_

Print Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**I HAVE READ THE DISCIPLINE POLICY AND I AGREE TO THE SPECIFICS OUTLINED IN THE POLICY.**

Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Release of Student Photographs and Interviews:**

Occasionally photographs and interviews are taken for our Minerva Summer Youth Program newsletter.

- ☐ I give the MYP permission to publish photographs or interviews of my child as it deems necessary and appropriate.
- ☐ I do not give the MYP permission to publish photographs or interviews of my child.

\_\_\_\_\_  
*Parent/Guardian Signature*

\_\_\_\_\_  
*Date*

**Person(s) who are authorized to pick up child from Minerva Youth Program: (\* 3 limit, no need to list self)**

Name	Relationship
1.	
2.	
3.	

**Registration forms are due by June 6th.**

Please return forms to Lynn Green at Minerva Central School or mail to  
Town of Minerva, PO Box 937, Minerva NY 12851