DIPÅTTAMENTON ASUNTON MANHOBEN

Department of Youth Affairs
Government of Guam
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Barrigada, Guam 96921
Tel: (671)735-5010 Fax: (671)734-7536

[ ]HAYA [ ]KATTAN [ ]LAGU
COMMUNITY SOCIAL DEVELOPMENT UNIT

Registration Type: [ ]Community Kids Program: ( )Afterschool ( )Summer Date:_____
[ ]Community Service [ ]Service Learning [ ]Other:_____

Participant Name: _____ Age: _____
Last First M.I.

Home/Physical Address:_____

Mailing Address:_____

Date of Birth:_____ Gender: [ ] Female [ ]Male U.S. Citizen: [ ]Yes [ ]No

School:_____ Grade:_____

Ethnicity:_____ Citizenship/Country Origin:_____

Contact Number(s):_____
Home Mobile

Alternate Number(s):_____

Mother/Guardian:_____
Last First M.I.

Mother/Guardian employer:_____ Work#:_____

Father/Guardian:_____
Last First M.I.

Father/Guardian employer:_____ Work#:_____

EMERGENCY CONTACT

Name:_____ Relationship:_____

Employer:_____ Employer Address:_____

Contact Number(s):_____

TRANSPORTATION AUTHORIZATION

The following individuals are authorized to drop-off and/or pick-up my child:

1. Name:_____ Relationship:_____ Tel#:_____
2. Name:_____ Relationship:_____ Tel#:_____
3. Name:_____ Relationship:_____ Tel#:_____
4. Name:_____ Relationship:_____ Tel#:_____

MEDICAL INFORMAITON

1) Are there any physical limitations that your child has that we need to be aware of? [ ]No [ ]Yes
If yes, explain:_____
2) Does your child have any allergies? [ ]No [ ]Yes
If yes, explain:_____
3) Does your child have any medical conditions? [ ]No [ ]Yes
If yes, explain:_____
4) Does your child take any medications as prescribed by a physician? [ ]No [ ]Yes
If yes, explain:_____
5) Does your child have any dietary restrictions as prescribed by a physician? [ ]No [ ]Yes
If yes, explain:_____
6) Does your child have medical insurance coverage? [ ]No [ ]Yes
If yes, name of insurance coverage:_____

EMERGENCY MEDICAL AUTHORIZATION

In the event of a medical emergency, I hereby authorize the medical treatment of my child

_____
Child's Name

Hospital Preference: [ ]No [ ]Yes **GMHA** and/or [ ]No [ ]Yes **GRMC**
****Please note that the hospital preference is at the discretion of the EMT when ambulatory services are provided depending on the urgent care needs. ****

Parent/Guardian:_____
Signature Print Name Date

I M P O R T A N T

PICK-UP TIME IS NO LATER THAN **5:00 PM.** FAILURE TO COMPLY AND/OR CONTINUED NON-COMPLIANCE WILL RESULT IN THE SUSPENSION OR TERMINATION FROM THE PROGRAM.

_____Parent/Guardian initials

D Y A C O N S E N T & W A I V E R O F L I A B I L I T Y

I [Parent/Guardian]_____ hereby give my permission for my child _____ to participate in **ALL** of the Department of Youth Affairs' (DYA) resource center activities and field trips. I expressively waive any and all claims against DYA, its employee's, volunteer's, agent's representative's, and sponsor's, arising from or in connection with any accident, injury, illness or other damages that may be incurred by my child _____or on said property in connection with any incident during my child's participation in any of the resource center activities.

As the parent/guardian, I have read and understand completely, and agree individually and on behalf of my child or ward, to the terms of the above DYA consent & waiver of liability contract and registration terms. I have also reviewed all the terms of the registration with my child.

Parent/Guardian:_____
Signature Print Name Date

Child:_____
Signature Print Name Date

- How did you learn about our resource center's programs/services?

Answer:_____