In order for this application to be processed, bring the following items to City Union Mission’s Family Center, 1310 Wabash:

1) Completed Application 2) Proof of date of birth 3) Medical Insurance Information

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2020 VYC City Camp Registration Form-FHR0302.docx
rev 5/4/2020 3:53:00 PM
MEDICAL FORM
Children with special needs are taken on a case-by-case basis.

ADDITIONAL EMERGENCY CONTACT INFORMATION
People with whom City Union Mission can exchange emergency information and through whom a responsible party can potentially be contacted...Also, if the registrant is a minor, someone to whom he or she may be released when necessary (including scheduled pick-up time)...Finally, someone who may give permission to another individual to pick up. **Information for positive ID must be provided.

*Second Emergency Contact
(Spouse/Parent/Guardian/Next of Kin)
____________________________________________________
**Date of Birth __________ Relationship to Registrant
____________________________________________________

*Third Emergency Contact
____________________________________________________
**Date of Birth __________ Relationship to Registrant
____________________________________________________

*Fourth Emergency Contact
____________________________________________________
**Date of Birth __________ Relationship to Registrant
____________________________________________________

*For every item below, please provide an answer or write N/A.

Any allergies to food or medications (please explain) __________________________________________________________
________________________________________________________

Other allergies (specify) __________________________________________

*Current medications (send in prescription bottle with instructions)

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Reason for Use</th>
<th>Dosage (if known)</th>
<th>Frequency (if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Operations or serious injuries (include dates) ______________________________________________________________

Chronic or recurring illness or medical condition

<table>
<thead>
<tr>
<th>Y/N</th>
<th>Condition</th>
<th>Y/N</th>
<th>Condition</th>
<th>Y/N</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y/N</td>
<td>Asthma</td>
<td>Y/N</td>
<td>Diabetes/Pre-Diabetes</td>
<td>Y/N</td>
<td>ADD / ADHD</td>
</tr>
<tr>
<td>Y/N</td>
<td>Visually Impaired</td>
<td>Y/N</td>
<td>Behaviorally Challenged</td>
<td>Y/N</td>
<td>Emotionally Challenged</td>
</tr>
<tr>
<td>Y/N</td>
<td>Physically Handicapped</td>
<td>Y/N</td>
<td>Hearing Impaired</td>
<td>Y/N</td>
<td>Learning Disabled</td>
</tr>
<tr>
<td>Y/N</td>
<td>Frequent Ear Infections</td>
<td>Y/N</td>
<td>Hypertension</td>
<td>Y/N</td>
<td>Heart Defect/Disease</td>
</tr>
<tr>
<td>Y/N</td>
<td>Seizures</td>
<td>Y/N</td>
<td>Bleeding/Clothing Disorder</td>
<td>Y/N</td>
<td>Frequent nose bleeds</td>
</tr>
<tr>
<td>Y/N</td>
<td>Bed Bug Bites</td>
<td>Y/N</td>
<td>Runner</td>
<td>Y/N</td>
<td>Other</td>
</tr>
</tbody>
</table>

INSURANCE INFORMATION

☐ Insurance information attached. (Copy with waiver)
(Company Name, Policy Number, Policy Holder Name, Group Number, Insurance company address and phone number)

☐ Does not have insurance. Only waiver is attached.

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