



REGISTRATION FORM

Today's Date:					
ATTENDEE'S INFORMATION					
Attendee's Last name:		First:	Middle Initial:	Marital status:	
Are you a student? <input type="radio"/> Yes <input type="radio"/> No	Are you a parent/adult? <input type="radio"/> Yes <input type="radio"/> No	Grade Level:		Birth date:	Age: Sex: <input type="radio"/> M <input type="radio"/> F
Address: (Street # & Name, City, State & Zip Code)					
Social Security no.: (If Applicable)		Home phone no.: [Phone]		Cell phone no.: [Phone]	
Occupation: (If Applicable)		Address (Street, City, State & Zip Code):		Email:	
Why did you choose this program?					
PARENT/GUARDIAN INFORMATION					
Relationship:	Name:	Address (If different):		Home/Mobile #:	
Is the attendee prescribed an inhaler? (If yes, please explain any instructions)	<input type="radio"/> Yes <input type="radio"/> No	Does the attendee have any allergies, chronic illness or medical conditions? (If yes, please describe)		<input type="radio"/> Yes <input type="radio"/> No	
Email: (If different)	Employer: [Employer]	Employer address: [Address]		Employer phone no.: [Phone]	
Please indicate primary insurance: (If Applicable)					
Primary Physician's Name:	Physician's Address:	City:	State:	Zip:	Phone #:
Name of secondary insurance (if applicable):		Physician's Address:		State & Zip:	Phone #:
IN CASE OF EMERGENCY & AUTHORIZATION TO PICK UP SCHOOL AGE ATTENDEE					
Name of local friend or relative (living or not living at the same address):			Relationship to attendee:		
Phone #:					

Informed Consent and Acknowledgement

I hereby give my approval for my child's participation in any and all activities prepared by Know Your Self Worth, Inc. and CEBG NC during the selected F.L.I.P Program. In exchange for the acceptance of said child's candidacy by Know Your Self Worth, Inc. and CEBG NC., I assume all risk and hazards incidental to the conduct of the activities, and release, absolve and hold harmless Know Your Self Worth, Inc. and CEBG NC and all its respective officers, agents, and representatives from any and all liability for injuries to said child arising out of traveling to, participating in, or returning from selected camp sessions.

In case of injury to said child, I hereby waive all claims against Know Your Self Worth, Inc. and CEBG NC including all staff and affiliates, all participants, sponsoring agencies, advertisers, and, if applicable, owners and lessors of premises used to conduct the event. There is a risk of being injured that is inherent in all activities. Some of these injuries include, but are not limited to, the risk of fractures, paralysis, or death.

Attendee/Guardian Signature

Date

Medical Release and Authorization

As Parent and/or Guardian of the named attendee, I hereby authorize the diagnosis and treatment by a qualified and licensed medical professional, of the minor child, in the event of a medical emergency, which in the opinion of the attending medical professional, requires immediate attention to prevent further endangerment of the minor's life, physical disfigurement, physical impairment, or other undue pain, suffering or discomfort, if delayed.

Permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, x-ray examination and immunizations for the named athlete. In the event of an emergency arising out of serious illness, the need for major surgery, or significant accidental injury, I understand that every attempt will be made by the attending physician to contact me in the most expeditious way possible. This authorization is granted only after a reasonable effort has been made to reach me.

Permission is also granted to the Know Your Self Worth, Inc. and CEBG NC and its affiliates including Directors, all staff and affiliates, all participants, sponsoring agencies, volunteers and parents to provide the needed emergency treatment prior to the child's admission to the medical facility.

Release authorized on the dates and/or duration of the registered season.

This release is authorized and executed of my own free will, with the sole purpose of authorizing medical treatment under emergency circumstances, for the protection of life and limb of the named minor child, in my absence.

Confirmation

BY ACKNOWLEDGING AND SIGNING BELOW, I AM CONFIRMING MY CONSENT, ACKNOWLEDGMENT, MEDICAL RELEASE & AUTHORIZATION. THE TYPED OR ELECTRONIC SIGNATURE WILL BE EQUALLY AS BINDING AS AN ORIGINAL MANUAL PAPER SIGNATURE.

Attendee/Guardian Signature

Date

Keturah Rucker
Founder & Director
krucker@capbizgroup.com
(704) 878-1177

Jannie Jones
Assistant Director
janniejones46@gmail.com
(704) 245-3143

www.capbizgroupnc.com
www.flipprogram.org

