DATE: _____

YOUNG LIFE CAPERNAUM

An Outreach to Teens and Young Adults with
Developmental Disabilities in our Community

REGISTRATION FORM:

STUDENT'S NAME:_____ AGE:_____

PARENT'S NAMES:_____

ADDRESS:_____HOME PHONE:_____

CITY:_____STATE:_____ZIP_____

MOM'S CELL: _____ DAD'S CELL:_____

E-MAIL ADDRESS:_____BIRTHDATE_____

SCHOOL:_____GRADE: _____

TRANSITION PROGRAM OR JOB_____

DISABILITY: _____ T SHIRT SIZE_____

INFORMATION THAT WOULD BE HELPFUL IN BUILDING A BETTER UNDERSTANDING/RELATIONSHIP WITH YOUR SON OR DAUGHTER (COMMUNICATION, TRIGGERS, ETC):_____

_____

_____

INTERESTS, HOBBIES OR OUTSIDE ACTIVITIES THEY ENJOY OR ARE INVOLVED IN: _____

_____

_____

IN CASE OF EMERGENCY CONTACT (ANY NAME NOT LISTED ABOVE & NUMBER):_____

_____

PARENT'S SIGNATURE (for those under18):_____

RELIGIOUS PREFERENCE OR CHURCH AFFILIATION (if any):_____

I hereby grant permission to Young Life the right to use, reproduce photographs and videos of my child without compensation or approval rights for use in material created for purposes of promoting the activities of Young Life Capernaum_____.

Return to Young Life Capernaum Leader
Or mail to: Omaha Young Life
2324 Bob Boozer Dr.
Omaha, NE 68130

PHOTO

Name of Son/Daughter: _____

Primary Emergency Contact: _____Phone: _____

Secondary Contact: _____Phone: _____

CHECK ALL THAT APPLY:

☐ Uses sign language ☐ Has a shunt ☐ Has a rod supporting bones
☐ Uses a language board ☐ Uses a hearing aid ☐ Uses a wheelchair
☐ Uses a walker ☐ Uses toilet independently – or any instructions_____
☐ Wears adult briefs – any special instructions?_____

Any other health information we should know to help us be able to serve your son or daughter? _____

CHRONIC, RECURRING AND SPECIAL HEALTH CONDITIONS

(Check all that apply and explain below)

☐ Arthritis ☐ Aspergers ☐ Asthma
☐ Attention-Deficit/Hyperactivity Disorder ☐ Autism ☐ Behavioral or Development Problems
☐ Cerebral Palsy ☐ Cystic Fibrosis ☐ Dental Problems
☐ Diabetes ☐ Down Syndrome ☐ Head or Spinal Injury
☐ Hearing Impairment ☐ Heart Disease ☐ Kidney Disease
☐ Muscular Dystrophy ☐ Seizures ☐ Sickle Cell Disease (not trait)
☐ Spina Bifida

Explanation:

_____

_____

ALERGIES: (Food, Drugs, Plants, Insects and Latex)

_____

_____

_____

MEDICATION INFORMATION:

PRESCRIPTION NAME	DOSAGE

Parent Signature_____

Parent or Guardian of: _____

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