

D.I.V.A In Training APPLICATION
(Registration Fee due with submission of application)

Personal:

Name: _____

Physical Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address: (if different from above) _____

City: _____ State: _____ Zip Code: _____

Home Phone: () _____ - _____ Cell Phone: () _____ - _____

Age: _____ D.O.B ____/____/____ SSN: _____ - _____ - _____

Email Address: _____

Myspace Address: _____

Ethnic Group: (circle all that apply) Caucasian African American Hispanic Asian

Other (please explain) _____

Name of Parent/Guardian in residence: _____

Driver's License #: (if applicable) _____ Issuing State: _____

Expiration Date: ____/____/____

Name of Auto Insurance Co. _____

Auto Insurance Policy #: _____

Education:

Are you currently in school? Y N

If YES, please complete the following section.

Name of School: _____

Grade: _____ Graduation Date (if applicable): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: () _____ - _____

List Additional Family Members in Program:

Name	Age
_____	_____
_____	_____
_____	_____
_____	_____

In Case of Emergency:

Contact's Name: _____

Phone #: () _____ - _____ Cell #: () _____ - _____ Relationship: _____

Contact's Name: _____

Phone #: () _____ - _____ Cell #: () _____ - _____ Relationship: _____

Medical Information:

Physician: _____ Hospital/Clinic: _____

Phone #: () _____ - _____

Address: _____

City: _____ State: _____ Zip Code: _____

Medication: _____

Allergies: _____

Physical Disabilities/Illness: _____

Mental Disabilities/Illness: _____

If picked up by other than Parent or Guardian, please list below:

Last First Middle Initial

Street # Name Apt# Zip

Phone number

Last First Middle Initial

Street # Name Apt# Zip

Phone number

Last First Middle Initial

Street # Name Apt# Zip

Phone number

(Must show proper ID before D.I.V.A's will release child)

D.I.V.A's

(Divine Intercession for Virtuous Adolescents)

Medical Release and Emergency Information

Name _____ Date of Birth ___/___/___ Home Phone _____

Last

First

Middle Initial

Address _____

Street #

Name

Apt. #

Zip

Father/Guardians Name _____ Employer _____

Business Phone _____ Cell Phone _____

Mother/Guardians Name _____ Employer _____

Business Phone _____ Cell Phone _____

In case of illness or injury, please call this number first _____

Alternative Adult _____ Phone number _____ Relationship _____

Alternative Adult _____ Phone number _____ Relationship _____

D.I.V.A's does NOT assume any financial responsibility but does wish to provide the best emergency service. By signing this card you are giving the appropriate personnel authority to call the EMS or obtain medical care if you or the Alternative Adult cannot be reached.

Family Doctor _____ Phone _____

Preferred Hospital _____ Phone _____

Signature of Parent or Guardian

Date

Parent/Guardian Social Security Number

My child has the following conditions: (Write Yes or No)

_____ Convulsive Disorder	_____ HIV/AIDS	_____ Speech Problem
_____ Visual Problems	_____ Diabetes	Other _____
_____ Orthopedic Disability	_____ Hearing Problems	_____
_____ Asthma*	_____ Heart Problem	_____

* If your child has Asthma, it must be diagnosed by your child's physician and an Asthma Action Plan needs to be provided to the Program Coordinator.

My child is allergic to _____

What type of Reaction _____

Does this child take medication on a regular basis Yes _____ No _____ If yes, explain:

