

SHINE For Girls - VA Student Application

Student Contact Information

Please indicate the program you intend to participate in:

Name

First Name

Last Name

Date of Birth

Month Day Year

Age

Grade

Address

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code Country

School

Math Teacher's Name

First Name

Last Name

Ethnicity

Language Spoken at Home:

What is your favorite subject in school?

What is your least favorite subject in school?

What are your current grades in math?

How would you be getting to SHINE every week?

How did you hear about SHINE?

Do you know anyone else who is applying? If so, please list their names.

Is there anything else we need to know?

Primary Parent/Guardian Contact Information

Name

First Name

Last Name

Relation to Student:

Primary Phone Number

Primary E-mail

Assignment, Consent, and Release

This release is executed for _____ (Student's Name),

by _____ (Parents Name) to SHINE For Girls.

I/We, the undersign, on behalf of _____ (Student's Name),

and for those who would claim under, through, or for him/herby:

attending the SHINE Program.

Yes

Consent that SHINE or TV, newspaper, or radio outlets may publish, or use said photographs and/or film and/or likenesses for itself, in a manner consistent with SHINE policies and procedures.

Yes

I/We hereby waive any right that I/We may have to inspect and/or approve the finished product or press release that may be used in connection with the photographs, films, or likenesses.

Yes

I/We represent and covenant that I/We have read and fully understand the above paragraphs and knowingly and voluntarily execute this ASSIGNMENT, CONSENT, AND RELEASE.

Yes

Primary Parent/Gaurdian Electronic Signature

Date

Month Day Year

Emergency Medical Care Form

Mother's Name: (if not applicable, please mark each space with a "-")

First Name

Last Name

Day Phone

Area Code Phone Number

Father's Name: (if not applicable, please mark each space with a "-")

First Name

Last Name

Day Phone

<div></div>	<div></div>
Area Code	Phone Number

Emergency Contact

<div></div>
First Name
<div></div>
Last Name

Day Phone

<div></div>	<div></div>
Area Code	Phone Number

Chronic Medical Conditions (requiring ongoing care):

Prescription Medicines (if used regularly):

Family Physician:

Health Care Provider:

Date of Last Tetanus Booster:

<div></div>	<div></div>	<div></div>
Month	Day	Year

Please list any other health issues or concerns that mentors should be aware of:

I am not aware of any medical conditions which would interfere with my daughter’s participation in this activity and I hereby grant permission for my child to participate in SHINE.

Yes

I grant permission for my child to participate for the selected dates.

Yes

Additionally, in case of emergency and if I/we cannot be reached, I, the undersigned parent of the above-named child, do hereby authorize the SHINE program mentors to seek medical attention deemed necessary, by qualified medical personnel, during the entire time that my child is participating in this program.

Yes

I/we understand that I/we will be responsible for any medical charges incurred in the treatment of my child, in the case of an emergency, that are not covered by my family's health insurance.

Yes

Parent/Gaurdian Electronic Signature:

Student Electronic Signature:

Signature

That's it! By digitally signing below, you confirm that you are a 5th, 6th, 7th, or 8th grade girl living in the Greater Washington DC area (including DC, Virginia, and Maryland). You also confirm that you have filled out the Press Release & Medical History / Emergency Contact forms above and have answered all of the questions truthfully.

Primary Parent/Gaurdian Signature:

Date

Month	Day	Year