

Cultural Connections for Aboriginal Youth





Name:		Education:	Gender:
		<input type="checkbox"/> Elementary	<input type="checkbox"/> Female
		<input type="checkbox"/> High School	<input type="checkbox"/> Male
		<input type="checkbox"/> Graduate	
Address:		Age Category:	Ethnic Origin:
		<input type="checkbox"/> 06 - 09	<input type="checkbox"/> First Nation
		<input type="checkbox"/> 10 - 14	<input type="checkbox"/> Métis
		<input type="checkbox"/> 15 - 24	<input type="checkbox"/> Inuit
		<input type="checkbox"/> 25 - 29	<input type="checkbox"/> Non-Aboriginal
Email:		What FN group:	

PHOTO & VIDEO AUTHORIZATION
Must be signed by legal guardian if under age of 19

<p>I, _____ the undersigned do hereby consent and agree that the pictures & videos taken of me be used for the Skookum Jim Friendship Centre/CCAY for purposes in publications or other visual processes.</p>	<p>The Skookum Jim Friendship Centre/CCAY reserves the right to have the final selection of which pictures/videos will be used. I understand that my involvement in this activity does not guarantee that my picture(s) or videos will be used.</p>
	
Participant's Signature:	Parent's or Guardian's Signature:

GUARDIAN, EMERGENCY, MEDICATION INFORMATION

First Aid treatment for my child is granted, should it be required		<input type="checkbox"/> Yes <input type="checkbox"/> No
GUARDIAN CONTACTS INFORMATION		
Name:		MEDICAL INFORMATION
H) Phone:		Allergies: <input type="checkbox"/> Yes <input type="checkbox"/> No
W) Phone:		Own Epipen: <input type="checkbox"/> Yes <input type="checkbox"/> No
Cell Phone as last resort, or urgent matters		Peanuts: <input type="checkbox"/> Yes <input type="checkbox"/> No
C) Phone:		Shellfish: <input type="checkbox"/> Yes <input type="checkbox"/> No
		Bee Stings: <input type="checkbox"/> Yes <input type="checkbox"/> No
		Animals:
		Other:
EMERGENCY CONTACTS INFORMATION		
Name:		Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No
Phone:		Name:
Authorized to pick up child: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name:		Dosage:
Phone:		
Authorized to pick up child: <input type="checkbox"/> Yes <input type="checkbox"/> No		
		
Guardian Signature, if under the age of 19	Participant Signature	



Contact information:
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