



# Fellowship Application

## Basic Information

Student Name: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Street Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Student Date of Birth: \_\_\_\_\_

School attending: \_\_\_\_\_

Current Grade: \_\_\_\_\_

Approximate T-shirt size (M, L, XL, XXL): \_\_\_\_\_

## Family Information

Adult(s) you live with: \_\_\_\_\_

Number of brothers: \_\_\_\_\_ Ages: \_\_\_\_\_

Number of sisters: \_\_\_\_\_ Ages: \_\_\_\_\_

Parent/guardian job: \_\_\_\_\_

Parent/guardian place of employment: \_\_\_\_\_

Parent/guardian job: \_\_\_\_\_

Parent/guardian place of employment: \_\_\_\_\_

Has anyone in your family graduated from college? \_\_\_\_\_ If so, please list:

<i>Family Member</i>	<i>College Attended</i>	<i>Year Graduated</i>

**Emergency Information**

Person to contact in an emergency: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Emergency phone number: \_\_\_\_\_

Insurance company and number: \_\_\_\_\_

Medicaid number: \_\_\_\_\_

Children's Health Insurance Program (CHIP) number: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications taking now: \_\_\_\_\_

Other important medical information: \_\_\_\_\_

\_\_\_\_\_

**Publicity waiver:** I agree to allow the Sunflower County Freedom Project to use pictures of my child or my child's work for use on the organization's website and other public material.

**Medical waiver:** I recognize that there are risks associated with Freedom Project activities, including martial arts training, and I agree to allow my child to participate in these activities. I release and hold harmless all SCFP staff from any liability for any injuries incurred as a result of these activities. Should a medical emergency arise, I give permission to all SCFP staff to seek medical treatment for my child. I understand and agree I will be held liable for all costs related to professional medical treatment, emergency or otherwise, my child receives during activities associated with the SCFP. I release and hold harmless all SCFP staff from any liability for treatment my child receives by third party medical providers.

**Tuition Commitment:** By signing this form, I commit to paying the full tuition of \$25 per month (\$300 per year) for the entire year. I recognize that I am liable for the full tuition regardless of whether or not my child attends Freedom Project events regularly. I understand that I also am liable for the full tuition even if my child is dismissed from the program for misdeeds.

**Parent/guardian signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



