Candidate Application Form
South Central Emmaus XXXIX • April 20 – 22, 2018
First United Methodist Church, 188 Rocky Rest Road, Shelton, CT 06484

Name: ______________________________ Nickname: ______________________________

Male / Female *(circle one)* Age: ________ Grade: __________ Date of Birth: ____/____/____

Address: ____

City: ______________________________ State: ______________ Zip: ________________

Home Phone: (______)______________ Candidate's Cell Phone: (______)______________

Candidate's Email: ______________________________ High School:__________________________

Place of worship (if applicable): ____

Have you been baptized? __________ (Not required)

Parent or Guardian Name(s): ____

Address: ____

City: ______________________________ State: ______________ Zip: ________________

Parent or Guardian email address: ____

Please give a brief statement of why you would like to participate in this Emmaus Weekend:

____

____

____

Attached is: a check (payable to ***South Central Emmaus***) / cash for the $50.00 weekend fee.*
(circle one of the above)

____
(Applicant signature)

Date: ______________________________

Sponsor Name: ______________________________

____
(Clergy signature)

Date: ______________________________

____
(Parent/Guardian signature)

Date: ______________________________

Phone: (____)______________________________

Phone: (____)______________________________

** Complete the health information on the attached Medical Release Form and return it to your sponsor with the $50.00 fee. Scholarships are available. Please talk to your sponsor if you need financial help.*

Turn page over to complete form

South Central Emmaus XXIX
Youth Medical Release Form

If I cannot be reached in a medical emergency, I give my permission for responsible representative(s) of the South Central Emmaus organization to secure proper treatment including hospitalization, anesthesia and surgery for:

____
(Print or type name of youth)

Medical information regarding youth named above (all information will remain confidential):

MEDICAL CONDITIONS THAT MIGHT AFFECT YOUR YOUTH'S HEALTH DURING THE WEEKEND (please include usual treatment):

____

____

MEDICATION / FOOD ALLERGIES / reaction and treatment if applicable:

____

____

MEDICATIONS BEING TAKEN (please include indication, dosage and times):

____

____

My youth will administer his / her own medications (yes / no)

DIETARY RESTRICTIONS/PREFERENCES (ie. vegetarian) ______________________________

DO YOU GIVE PERMISSION FOR A RESPONSIBLE ADULT TO ADMINISTER Yes / No
(circle all that apply) Tylenol Motrin Antacids Benadryl

Health Insurance Company: ____

Plan Type: ________________________ ID #: ____________________________

Group #: ____________________ Name of Insured: _________________________

Family Physician: ____________________________ Phone: (_____)________________

Signature of Parent or Guardian: __________________________________ Date: __________

Home Phone: (____)______________________ Cell (Name): (____)___________________

Email address: ____

Turn page over to complete form