GOLDEN KNIGHTS

Student Application Form

Please Print

Student Information

Name: ____

Address: ____

City: ________________________________ State: ______ Zip: ________

Date of Birth: _________________________ Grade Point Average/GPA: _____________

School Attending: ____

Mentee Phone Number: _(_____)__________________ Mentee Email: __________________________

How were you referred to us: ____

Upon Graduation, what do you plan to do:

_____College _____Vocational School _____Technical School _____Work _____Undecided _____Other

My goal is to become a: ____

____

What do you hope to get out of the Golden Knight's Program?

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Parent Information

Parent/Guardian's Name: ____

Phone: __(______)______________________ Email: ____

Address: ____

City: ________________________ State: _____ Zip: ________ Work Phone: ______________________

Alternate Phone(s): __(______)_____________________________ __(______)_____________________________

Emergency contacts who may pick up the student:

Name: _____________________________________ Relationship: _________________

Home Phone: _________________ Work Phone: _______________ Cell: ___________

Name: _____________________________________ Relationship: ____________________

Home Phone: _________________ Work Phone: _______________ Cell: ____________

Student Signature: ____ Date: __________

Parent/Guardian Signature: _______________________________________ Date: __________

Student Health Record

To the parent/guardian: The health of the student is primarily the responsibility of his parents or guardians. The Xi Mu Mu Chapter strongly recommends annual health examinations, dental checkups, and immunizations against preventable diseases. Our policy on health and safety implies a responsibility to the participants for their protection. It also implies the right of the organization to be assured, as far as possible, that the participants are physically able to take part in activities.

Student's Name:_________________________________ Parent/Guardian's Full Name: ________________________

Student's Full Address:____

Phone Number:_______________________________ Student's Birth Date:___________________________

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Family Physician's Name: __________________________ Physician's Phone Number:_(_____)______________________

Family Medical/ Hospital Insurance Carrier:____

Policy/Group Number: ____

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Part 1: Illnesses and Injuries (Check those that apply and give appropriate detail in Part 5)

Chronic or recurring Illnesses

_____Asthma _____Bleeding/Clotting Disorders _____Diabetes _____Ear Infections

_____ Heart Defect/Disease _____Hypertension _____Musculoskeletal Disorders _____Seizures

Other:____

____

Were any complicating medical problems noted in last health exam? If yes, please describe: _______________________

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____

If your child needs any medications while at this event, please indicate the medicine, dosage and times to be given in space provided below (part 6). All medications must be in their original containers. Your signature here authorizes the adult in charge to administer such medications as indicated.

Parent/Guardian Signature: _____________________________________ Date: _________

Part 2: Allergies:
(Check all that apply and specify nature of allergic reaction.)
________Animals ________Insect Stings ____________Drugs __________Plants __________Food
________Pollen _________Hay Fever Other (specify)____

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Part 3: Immunizations:

Are all of the Student's immunizations up to date? Yes _____ No _____ (If not, please explain in Part 5)

Date of last: DPT__________________ Tetanus_______________

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Part 4: Other Health Conditions:

(Check those that apply)

____Bed Wetting ____Emotional Disturbance ____Fainting ____Hearing Impairment ____Constipation

____Dental Appliances ____Nosebleeds ____Sleep Disturbances ____Motion Sickness ____Special Dietary Needs

____Wears glasses or contacts ____ Sickle Cell Trait or Disease ____Asthma ____HIV/AIDS

Other (specify)____

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Part 5: Notes:

(Please explain any items that are noted in previous sections. Indicate any information useful to the adult in charge in relation to any of these health conditions. Also indicate any activities to be restricted.)

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Part 6: Medication:

Directions: Please give detailed directions for any medications to be given to your child. Include dosage and times.

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I know of no reason(s) other than the information on this form, why my son should not participate in activities.

Parent/Guardian Signature: ___________________________________ Date: _________

Program Liability Form

PARENT AUTHORIZATION FOR MEDICAL EMERGENCY TREATMENT (Sign ONE section only)

In case of medical emergency, I understand every effort will be made to contact parents or guardian of the child. In the event I cannot be reached, I hereby give permission to the physician selected by authorized representative(s) of Xi Mu Mu Chapter to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child.
Student's Name: _______________________________
Parent/Guardian Signature: _____________________
Address: _____________________________________
____
Phone: __________________
Date: ___________________

(Sign only if you decline to sign release at left) I have been offered the opportunity to authorize emergency medical care as set forth (on left) and decline to authorize said emergency medical care without my approval and accept such complications as may occur should said medical care be needed and unavailable due to my being unavailable to provide the same.
Student's Name: _______________________________
Parent/Guardian Signature: ______________________
Address: _____________________________________
____
Phone: __________________
Date: ___________________

The Parent/Guardian agrees to hold harmless the men of the Xi Mu Mu Chapter of Omega Psi Phi Fraternity, Inc. and the Grand Chapter of Omega Psi Phi Fraternity, Inc. from any and all liability relating or occurring from any accidents or injuries resulting from you or your child's participation in any event in itself and travel to and from any event.

Furthermore, it is understood that any and all medical expenses incurred due to injuries sustained at any project or event organized by the Xi Mu Mu Chapter of Omega Psi Phi Fraternity, Inc. is the sole responsibility of the participant in the event(s). This is inclusive of pre-existing conditions, which may become aggravated due to you or your child's participation in any event(s).

It is also understood that no legal action will be brought against Xi Mu Mu Chapter of Omega Psi Phi Fraternity, Inc. or subsidiaries or authorized personnel by you or your child because of any matter directly or indirectly related to you and your child's participation in any session or events held by the Xi Mu Mu Alumni Chapter of Omega Psi Phi Fraternity, Inc.

Parent/Guardian's Authorization (PLEASE PRINT)

As a parent/guardian of ___________________________________, I request that he attend the Golden Knights Mentoring Program and take part in all activities. In case of emergency, the community sub-leader has my permission to give minor first aid or take my child to an emergency treatment facility.

I, (parent/guardian) ____________________________________, further request the community sub-leader or his representative to call a physician for medical care for my child, (child's name) _______________________________________, should an emergency arise. I understand that the program staff will make a conscientious effort to locate me via the telephone number provided at drop off as well as attempting to contact me at _______________________, before any action is taken but if it is not possible to locate me, I understand that I will accept all medical expenses.

By signing your name, you are stating that you have read and fully understand and are in agreement with this waiver

Parent/Guardian Signature: _______________________________________ Date: _________