**ROTARY DISTRICT 7850**

**RYLA 2015 REGISTRATION FORM**

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| --- |
| **Sponsoring Rotary Club Information:**  **The non-Refundable $375.00 fee is paid by the Rotary Club of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Name of Sponsoring Rotary Club**  **Contact Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #/email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Rotarian, please send the completed form and check to Larry Vars, PO Box 22, Lunenburg, VT 05906 (Lvars@pjnoyes.com) |

**RYLA Participant Information**

Congratulations! You have been awarded a scholarship to attend the Rotary Youth Leadership Awards (RYLA) Conference, held at Lyndon State College from **Friday, June 26, 8:00 am to Sunday, June 28, 2015, 1:00 pm**. Y**ou and your parent or legal guardian should complete this form together as well as the three (3) separate release forms one of which is the consent for medical treatment.** This form and the release forms are mandatory to meet the requirements of Rotary and our RYLA partner, Lyndon State College. Thank you in advance for completing these forms in detail and legibility.

**IMPORTANT!!! PLEASE PRINT LEGIBLY AND**

**RETURN THIS FORM TO THE ROTARY CONTACT PERSON LISTED ABOVE**

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Last Name Last Name First Name Middle Initial Sex (M/F)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address Mailing Address City / Town State (Province) Zip+4 (Postal) Code

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Physical Address, if different City / Town State (Province) Zip+4 (Postal) Code

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Name of School Attending in August City/Town Grade

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone Student Cell Phone

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: M\_\_\_\_\_\_\_\_ D \_\_\_\_\_\_ Year \_\_\_\_\_\_\_

Student Primary E-Mail Address

List prior Rotary activities in which you have participated, if any:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENT INFORMATION**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Legal Guardian #1 Last Name First Name Specify Relationship**

**(Mother, Father, Step-, Grandparent, Etc.)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mailing Address City / Town State (Province) Zip+4 (Postal) Code

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E-Mail #1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-Mail #2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Legal Guardian #2 Last Name First Name Specify Relationship**

**(Mother, Father, Step-, Grandparent, Etc.)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address City / Town State (Province) Zip+4 (Postal) Code

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Physical Address, if different City / Town State (Province) Zip+4 (Postal) Code

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E-Mail #1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-Mail #2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY INFORMATION**

Emergency Contact person must have legal authority to make medical decisions and be listed above.

#1 Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Best Daytime Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Best Nighttime: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#2 Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Best Daytime Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Best Nighttime: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CURRENT MEDICAL INFORMATION**

1. Do you have any allergic reactions (e.g., bee sting, drugs, foods, etc.?  Yes  No

If yes, please explain:

1. Will you be taking any prescribed medications while at RYLA?  Yes  No

If yes, what:

1. Do you have any chronic illnesses? (*e.g.*, diabetes, epilepsy, asthma, etc.)  Yes  No

If yes, what:

1. What is your current level of physical activity?
2. Do you have any conditions that might prevent you from any physical activities?  Yes  No

If yes, please list:

1. Have you experienced any injuries within the last 3 years?  Yes  No

(*e.g.*, dislocations, severe sprains, torn ligaments, separations, etc.)

If yes, list them, identify when the injuries occurred and the severity of the injury:

1. Have you fully recovered from this injury/these injuries?  Yes  No

If no, please list the injury/injuries still in recovery and your current status:

1. Are you currently being treated or have been by a physician within the past year?  Yes  No

If yes, please explain:

1. Do you have any physical disabilities?  Yes  No

If yes, please explain:

1. Do you wear contact lenses?  Yes  No
2. Have you had a tetanus shot?  Yes  No

Date of shot if known \_\_\_\_\_\_\_\_\_\_\_\_

RYLA Participant’s Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health insurance provider name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy holder’s name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please add any other medical information we should have. In particular, please add any details of allergies named above that we should know about.