MY CITY MY PASSION 2023 APPLICATION FORM

Return completed application to cpmacena@urbanlifecenter.org
by July 3rd, 2023

First Name _____
Last Name _____
Preferred Name _____Age: _____Date of Birth: _____
Social Security Number (optional) _____

PARENTS/GUARDIANS INFORMATION
Mother's name _____ Tel. Number _____
Father's name _____Tel. Number _____
Mailing Address _____
E-Mail Address_____
Cell Phone Number _____
Secondary Phone Number _____

CHURCH INFORMATION
Local Church
Pastor's Name_____
Pastor's Phone Number _____

EMERGENCY CONTACT INFORMATION
Please provide two emergency contacts:
Name _____
Relationship _____
Address _____
Primary Phone Number_____ Secondary Phone Number _____
E-Mail Address _____
Name _____
Relationship _____
Address
Primary Phone Number _____ Secondary Phone Number _____
E-Mail Address _____

Continue

REFERENCES
Please provide two personal/professional
references. One reference may be a personal friend.
Name_____
Nature of Relationship _____ Years known _____
E-mail Address _____
Phone Number _____

Name_____
Nature of Relationship_____ Years known _____
E-mail Address _____
Phone Number _____

Submit via email at cpmacena@urbanlifecenter.org or mail to:
Urban Life Center
Att. My City My Passion,
3223 Eastern Ave, Baltimore MD

COMPLETED APPLICATION INCLUDES:

Completed Application forms
.
$280 registration fee plus $45 (Six Flags) by July 3rd, 2023

Method of Payment
Check
Please make check payable to Urban Life Center (Memo: 2023 My City My Passion)
3223 Eastern Ave, Baltimore MD
Credit Card – Master Card
or Visa Only
Card Holder Name: _____
Credit Card #: _____
Exp. Date: _____Security Code/CVV:_____
Billing Address: _____
Email Required: _____
Daytime Phone #: _____

Full payment balance is due and becomes non-refundable a week prior to the event.

MEDICAL FORMS

PERSONAL INFORMATION
First Name _____
Last Name _____
Gender: ( ) Male ( )Female Age: _____Date of Birth: _____
Home Address: _____

DOCTOR'S INFORMATION
Doctor's Name _____ Tel. Number _____

MEDICAL INSURANCE INFORMATION
This teen is covered by family medical insurance ( ) yes. ( ) no
Please, include a copy of both sides of the insurance card if appropriate.
Insurance Company _____
Policy Number_____
Subscriber _____ Phone Number: _____

PARENT/GUARDIAN TO CONTACT IN CASE OF EMERGENCY OR ILLNESS
Name _____Relationship _____
Address _____
Primary Phone Number_____ Secondary Phone Number _____
E-Mail Address _____
ADDITIONAL CONTACT IN EVENT PARENTS/GUARDIAN CANNOT BE REACHED
Name _____
Relationship _____
Address _____
Primary Phone Number _____ Secondary Phone Number _____
E-Mail Address _____

ALLERGIES
( ) no known allergies.
( ) allergic to: ( ) medicine. ( ) food ( ) insects. ( ) other
Please describe below what the teen is allergic to and the reaction seen.

COVID-19 INFORMATION
( ) was sick with covid-19 in the past year
( ) vaccinated against Covid-19 ( ) Pfizer ( ) Moderna ( ) Johnson ( ) Other

PARENT/GUARDIAN AUTHORIZATION FOR HEALTH CARE

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a “need to know” basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child’s health record from providers who treat my child and these providers may talk with the program’s staff about my child’s health status.

SIGNATURE: _____ DATE: _____