Kansas
Office of the Governor
African American Affairs Commission

African American Youth Day at the State Capitol August 2, 2013

REGISTRATION FORM

Open to Students in 6th through 9th Grades ***Application Deadline: July 15, 2013***

Student Information

Name:			County:
Age:	Gender:	Grade:	County:
Street Address:		City:	Zip:
Phone:		Email	

Parent/Guardian Information

Name:
Emergency Contact Phone:

Group Information

Organization/School/Group (If Applicable):		
Contact:		
Street Address:	City:	Zip:
Phone:	Email:	

PARENTAL CONSENT AND RELEASE

I, being the parent or legal guardian of _____, do consent to my child attending African American Youth Day at the Capitol on August 2, 2013. I hereby acknowledge that I have read and understand this form. I hereby release and discharge the Kansas African American Affairs Commission, the State of Kansas, and its officers, agents and employees from all claims, demands and causes of action of every kind whatsoever for any damages and/or injuries which may result from my participation, or my child's participation in African American Youth Day at the Capitol**.** I further agree to hold harmless the Kansas African American Affairs Commission, the State of Kansas, and its officers, agents and employees, from liability for any damages or injuries resulting from any acts or failure to act on my part or my child's part or by others during our participation in said voluntary activities at African American Youth Day at the Capitol.

MEDICAL RELEASE

Further, being the parent or legal guardian of _____, I do consent to any medical, surgical, x-ray, anesthetic, or dental treatment that may be deemed necessary for my minor child. I understand that efforts will be made to contact me prior to treatment but, in the event I cannot be reached in an emergency, I give permission to the activity leader to make the decisions necessary for treatment. Should there be no activity leader available, I give permission to the attending physician to treat my minor child. As parent or legal guardian, I understand that I am responsible for the health care decisions of my minor child and agree that my insurance plan is the primary plan to pay for the medical, dental, or hospital care or treatment that is given to my minor child.

Signature of Parent/Guardian **Date**

_____ _____

Send Registration via mail, fax or email to: Mildred Edwards, Kansas African American Affairs Commission
900 SW Jackson, Room 101, Topeka, Kansas 66612
Phone: 785-296-4874 Fax: 785-296-1795 Email: ashley.wooten@ks.gov