

Youth Protection Program Participant Registration Form

Part I:

Name of program/activity/clinic: _____

Type of program/activity/clinic (please check all that apply):

Day camp (various activities) sports camp/clinics (day) sports camp (overnight)
tutoring Other: please specify: _____

Part II:

1. Minor/Youth Participant Information:

Last Name First Name MI

Minor/Youth participant: Date of Birth (DOB): _____ Age: _____ Gender: _____

Grade in School: _____ T-shirt size: _____ (some programs may offer this)

Address: _____

City: _____ State: _____ Zip code: _____

Reachable phone number: _() _____

Email (if applicable): _____

2. Minor/Youth participants parent or guardians' emergency contact information (reachable phone # and email)- please provide at least one:

(a) _____

Printed name of parent or legal guardian

Relationship to participant: parent grandparent family member friend other

Address: _____ City: _____

State: _____ Zip code: _____ Email: _____

() _____

Contact phone

() _____

Alternate phone

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(b) _____

Printed name of parent or legal guardian

Relationship to participant: parent grandparent family member friend other

Address: _____ **City:** _____

State: _____ **Zip code:** _____ **Email:** _____

(____) _____

Contact phone

(____) _____

Alternate phone

(c) _____

Printed name of parent or legal guardian

Relationship to participant: parent grandparent family member friend other

Address: _____ **City:** _____

State: _____ **Zip code:** _____ **Email:** _____

(____) _____

Contact phone

(____) _____

Alternate phone

(d) _____

Printed name of parent or legal guardian

Relationship to participant: parent grandparent family member friend other

Address: _____ **City:** _____

State: _____ **Zip code:** _____ **Email:** _____

(____) _____

Contact phone

(____) _____

Alternate phone

Part III:

1. Does your child have any physical impediment which would prevent them from participating fully in the above referenced program? **Yes** **No**

If yes, please explain/advise: _____

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2. *Does your child have any medical conditions which would prevent them from participating fully in the above referenced program? Yes No

If yes, please explain/advise: _____

3. *Do you wish to allow California State University, Monterey Bay (CSUMB) authorization to assess the necessity for Medical Treatment of your child while participating in the above reference program should they become injured or ill? Yes No

**For CSUMB to treat your child please review and sign the Medical Treatment Consent Form.*

I hereby give my consent for the minor/youth to participate in the _____ Program duly approved by the California State University, Monterey Bay. I further agree to relieve the Trustees of the California State University, the California State University Monterey Bay, the State of California, and their respective employees, staff members and agents of any, and all liabilities that may result from the named minors' participation in this program. If signing on behalf of a youth/minor participant, the undersigned parent/guardian of the student hereby authorizes/does not authorize staff members of the California State University Monterey Bay to act as agents for the undersigned parent/guardian.

I have been informed and understand there remains a risk of exposure to COVID-19. I understand that regardless of any precautions taken, an inherent risk of exposure to COVID-19 will exist.

*I hereby authorize consent to treat the below named minor participant.

I hereby do not authorize consent to treat the below named minor participant.

Youth Participants Full Name

Nickname (if applicable)

Printed Name of parent or legal guardian

Signature of parent or legal guardian

Date

****For CSUMB staff only:** Regardless if the parent/legal guardian has given consent to treat the minor/youth participant, attach the signed Medical Treatment Consent form to the Participant Registration Form.