DIVISION OF YOUTH SERVICES

DEPARTMENT OF COMMUNITY & CULTURAL AFFAIRS
COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS

2025 DYS Summer Youth Program
REGISTRATION FORM

REQUIRED DOCUMENTS:

	Completed Registration Form
	Copy of youth's Health Insurance (One of the following: Medicaid/ Moylan's/Traders/Aetna/Other)
	Copy of youth's valid ID (One of the following: Birth Certificate/School ID/Passport/Mayor's ID)

Received by:

_____

____/____/**2025** Time:_____

NOTE: Incomplete Registration Forms (without required documents or invalid documents) will not be accepted.

Kindly select a session you wish your youth to participate in:

☐ Session 1
July 07 – July 11, 2025
Mon – Fri (8:00 a.m. – 5:00 p.m.)
Kagman Community Center

☐ Session 2
July 14 – July 18, 2025
Mon – Fri (8:00 a.m. – 5:00 p.m.)
Tanapag Youth Center

Please fill out ALL sections regarding the Participant(s):

Last Name	First Name	Gender (M/F)	Age	Citizenship	Ethnicity	Village of Residence

	Parent/ Legal Guardian 1	Parent/ Legal Guardian 2	Emergency Contact *(other than Parent/Legal Guardian)*
Print Name			
Relationship			
Cellphone number			
Home/Work phone			
Email Address			

HOUSEHOLD ANNUAL INCOME *(for statistical purposes only)*:

☐ $0 - $10,000 ☐ $25,000 - $40,001 ☐ $55,001 and above

☐ $10,001 - $25,000 ☐ $40,001 - $55,000

PRIMARY LANGUAGE: _____ **SECONDARY LANGUAGE**: _____

SPECIAL ACCOMMODATION:

1) **Does the participant need any special help?** *(Ex: "Ken gets distracted quickly, needs reminders to stay focused.")*

_____

_____

2) **Does the participant have any Allergy:** *(Ex: "Maria is allergic to seafood" or "Mark is allergic to dust")*

_____

_____

3) **Does the participant need medical care or under any medication(s)?** ☐ Yes ☐ No
If yes, please indicate what staff/volunteers need to be aware of to better serve your youth.
(*Ex: "John has asthma and needs to use his inhaler every 3 hours.")*

_____

_____

4) **Other information we need to know about the participant:**

_____

_____

Family Health Care Clinic/Center: _____

Physician's Name: _____ **Phone #:** _____

PARENTAL CONSENT

I, _____, parent/legal guardian of _____, hereby give permission for my child to participate in the 2025 DYS Summer Youth Program, including the Workshop on topics of sexual assault and sexual abuse, teen dating violence, domestic violence, access to health resources, alcohol, tobacco and other drugs coordinated by DCCA-Division of Youth Services and its partnering agencies.

WAIVER OF LIABILITY

I, _____, parent/guardian of _____, a participant of the 2025 DYS Summer Youth Program, do hereby assume all the foregoing risks and accept personal responsibility for any damages or injuries which may arise from my child participating in the 2025 DYS Summer Youth Program. I discharge ALL claims, demands, causes of actions, suits or judgments against the Department of Community and Cultural Affairs, Division of Youth Services, it's Administrators, Directors, Agents, Coordinators, staff, trainees, volunteers and other partner agencies and organizations involved in the coordination and implementation of program(s).

MEDIA RELEASE

I, _____, parent/guardian of _____, do hereby give consent and authorize employees, volunteers and/or partner agencies of the DCCA-Division of Youth Services to take video images, photographs, audio recordings, or any other visual or audio reproduction of my child indicated above while participating in activities sponsored by DCCA-Division of Youth Services to be used, distributed, or shown as DCCA-Division of Youth Services sees fit. Such distribution may include, but not limited to DCCA-Division of Youth Services media publications such as newspaper or magazine articles, news reports, agency brochures, websites, grant reporting, and etc.

EMERGENCY MEDICAL AUTHORIZATION

I, _____, parent/guardian of _____, do authorize DCCA-Division of Youth Services, in the event that I cannot be contacted or if any urgency dictates, to act *in loco parentis* for the Child in respect of any circumstances, including any accident or illness, which may necessitate medical treatment, including surgery, and on my behalf to authorize any such treatment or surgery which they, in their sole discretion, (which discretion shall not be unreasonably exercised), may deem necessary. Medical treatment for the Child may also include dental surgery, x-ray, blood transfusion, anesthetic and medication provided any such medical treatment is performed by a duly licensed practitioner. I hereby accept full liability for all costs incurred through such medical treatment for my child.

I acknowledge that I have read and fully understood the contents of the Consent, Waiver of Liability, Media Release and Emergency Medical Authorization forms. By affixing my signature below, I agree to the terms and conditions stated above. I also understand that my child is bound to abide to the RULES and REGULATIONS set forth by the program.

Parent/Guardian Name: _____
(Print Name)

Parent/Guardian Signature: _____ Date: _____

For DYS Use Only

Enrollment Date & Time: _____ DYS-FYEP Staff's Name: _____

Date Withdrew: _____ Reason: _____