



# DIVISION OF YOUTH SERVICES

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



## 2026 Summer Youth Empowerment Camp REGISTRATION FORM

July 27-31, 2026. For children 5 – 12 years old

### REQUIRED DOCUMENTS:

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

<b>Received by:</b> _____
____ / ____ /2026 Time: _____

**NOTE:** Incomplete Registration Forms (without any of the required documents) will not be accepted.

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
<b>Print Name</b>			
<b>Relationship</b>			
<b>Cellphone number</b>			
<b>Home/Work phone</b>			
<b>Email Address</b>			

### HOUSEHOLD ANNUAL INCOME:

- \$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 your child(ren) need any special help?** (Ex: "Joseph gets distracted quickly, needs a buddy system to keep him focused.")

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2) **Does your child(ren) have any Allergy:** (Ex: "Maria is allergic to seafood" or "Ken is allergic to Penicillin")

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3) **Does your child(ren) 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 child(ren).  
(Ex: "My son Johnny has asthma and needs to use his inhaler every 3 hours.")

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4) **Other information we need to know about child(ren):**

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**Family Health Care Clinic/Center:** \_\_\_\_\_

**Physician's Name:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

## PARENTAL CONSENT

I, \_\_\_\_\_, parent/legal guardian of \_\_\_\_\_, hereby give permission for my child(ren) to participate in the 2026 Summer Youth Empowerment Camp coordinated by DCCA-Division of Youth Services.

## WAIVER OF LIABILITY

I, \_\_\_\_\_, parent/guardian of \_\_\_\_\_, a participant at the DCCA-Division of Youth Services 2026 Summer Youth Empowerment Camp, 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 DCCA-Division of Youth Services 2026 Summer Youth Empowerment Camp. 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: \_\_\_\_\_