

ACT
Addison Central Teens
94 Main Street Middlebury, VT 05753
www.addisonteens.com
Phone (802) 388-3910

Addison Central Teens Registration Form

Teen name _____ Teen e-mail _____

DOB _____ Age _____ Grade _____ School _____

House # and Street _____ Town _____ Zip _____

Home Phone _____ Teen cell _____

To receive notification/invitation of ACT events and programs please join the ACT group on **facebook** <http://www.facebook.com/group.php?gid=10348016979>

1. **94 Main** is a *SUBSTANCE FREE* space
2. At **94 Main** we *RESPECT* ourselves, each other, our space and our surroundings
3. At **94 Main** we all have the *RIGHT to feel SAFE; NO VIOLENCE* in speech or actions
4. **94 Main** is a community space and *EVERYONE is RESPONSIBLE for CLEANING UP* after him/herself

I agree that my **name** and **photographic image** may be used to publicize the work of ACT. Yes NO

By signing below **I agree to the above. I agree to follow the rules and policies of ACT** while at “94 Main” and when participating in any ACT events and programs.

Teen Signature _____ Date _____

By signing below, I state my understanding that my child will be using the teen center at “94 Main” and is required to follow the rules and policies of ACT while at “94 Main” and when participating in any ACT events and programs.

Parent name (please print) _____

Parent signature _____ Date _____

Are you interested in volunteering for drop-in hours? Yes NO or Special events? Yes NO

Would you like to share your talent/hobby with the teens? Yes NO Specify _____

PLEASE TURN OVER FOR INSURANCE INFORMATION/CONSENT TO TREAT
Insurance Information / Consent for Medical Treatment and or Transportation

Name of teen (please print) _____

Please provide any information that is *DIFFERENT* from your teen's information on page 1 (reverse side)

Mother / Guardian (please print)

Father / Guardian (please print)

| | |
|---|---|
| Name: _____ | Name: _____ |
| Address: _____ House/Apt # Street | Address: _____ House/Apt # Street |
| _____ Town Zip | _____ Town Zip |
| Home phone: _____ | Home phone: _____ |
| Cell phone: _____ | Cell phone: _____ |
| Work phone: _____ | Work phone: _____ |
| e-mail: _____ | e-mail: _____ |

Would you like to receive ACT newsletters, event and program notifications via e-mail? Yes No

Alternate Emergency Contact: (please print)

| | |
|-------------------|-----------------------------|
| Name: _____ | Relationship to teen: _____ |
| Home phone: _____ | Work or Cell phone: _____ |

Medical Information:

| |
|---------------------------|
| Allergies: _____ |
| Medical Conditions: _____ |
| Medications: _____ |

I agree that the name and photo image of my child may be used to publicize the work of ACT Yes No

I give permission for my child to be transported by the ACT staff *to* and *from* ACT events Yes No

*For special events / trips such as overnights or out of town trips, a separate permission slip is required.

By signing this document, I give my consent for any representative of ACT to seek medical assistance for my child while participating in ACT activities.

Parent / guardian name (please print)

Signature of parent/guardian

Date