

STUDENT APPLICATION

Rotary Youth Leadership Awards Conference
Sponsored by Rotary Clubs of District 6560
March 15 – 17, 2024

PART ONE OF TWO

Sponsoring Club Information

Sponsoring Club Name	Sponsoring Club Contact Name
Phone	Email

Student Delegates Information

Name	Sweatshirt Size Choose size	
Highschool	Age	Gender
Home Address	City	Zip
Email Address	Phone	Type
Emergency Name	Emergency Phone	Grade

Provide a brief bio of applicant by completing below or attach the student's Resume.

Special Interests and Talents

Extra Curricular Club or Athletic Activities

Awards (School/Civic)

Leadership Positions

Please include a recent school photo here

STUDENT APPLICATION

PART TWO OF TWO

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DISTRICT 6560 RYLA HEALTH AND CONSENT FORM

Health Contact Information

Student Name	Birthdate	Gender
Parent/ Guardian	Phone	Type
Home Address	City	Zip
Business Address	City	Zip
Business Email	Phone	Type
Emergency Email	Emergency Phone	Emergency Contact Name
Dentist Name	Dentist Phone	Medical Insurance Carrier
Family Physician Name	Family Physician Phone	Insurance Policy Number

Health History *(To be completed by parent)*

Do you have any allergies?

Please check those that apply:

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Poison Ivy |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Insect Stings |
| <input type="checkbox"/> Other Drugs | <input type="checkbox"/> Foods |

Disorders/Diseases (approximate dates)

Please check the box if you have experienced any of the following and enter the applicable date alongside the item.

- | | |
|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Ear Infections |
| <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Heart Defect/Disease |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Other Disorders | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Strep Throat | <input type="checkbox"/> Bleeding Disorders |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Measles |
| <input type="checkbox"/> German measles | <input type="checkbox"/> Mumps |

Other diseases or details of above

Operations or serious injuries (include dates)

Chronic or recurring illnesses

List Medications

Parent's Authorization

IMPORTANT-- MUST BE COMPLETED FOR ATTENDANCE

This health history is correct as far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted by me and the examining physician. I hereby give permission to the physician selected by the camp director to order x-rays, routine tests and treatment for the health of my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above. Certain photos and video may be released to media, colleges, civic or school-related organizations and state or governmental agencies as well as published in programs or used in presentations for Rotary District 6560.

Parent/Guardian Signature
& Date

Witness Signature & Date