S.H.O.P
(Safety, Health, Opportunities & Practice)
Youth Program

STUDENT INFORMATION

First Name | Middle Initial | Last Name

Home Address | City | State | Zip Code

Date of Birth | Age | Gender | Primary Language

School | Grade | Any Food/Allergies? | Medication?

PARENT INFORMATION

Parent/Guardian Name(s)

Home Address (if different from above) | City | State | Zip Code

Text Phone Number | Work Phone Number | Home Phone Number | Email Address

EMERGENCY CONTACT INFORMATION

First Name | Middle Name | Last Name

Relationship to Child | Home Phone Number | Alternative Number

*This Program is funded by the United States Department of Justice Office of Community-Oriented Policing Services (COPS), and the United States Department of Health and Human Services Office of Minority Health

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Permission Form for Photo/ Video/ Filming

I authorize and give permission that the Health Education Council photograph and video tape or film my child, and I as well, as long as my children participate in the program. I recognize that neither I, nor my children will be compensated by the center or by a third person for the use of the images. I give permission to the Health Education Council to use the images to demonstrate program impact on several social media, including, but not limited to Health Education Council's website, Facebook, and Instagram pages, the newsletters, and the websites of the Office of Minority Health, Community-Oriented Policing Services, and the Center for Court Innovation.

Parent Signature/ Guardian_____ Date_____

Fieldtrip Permission

I give permission for my child (above stated students) to participate in all of the fieldtrips that are coordinated by the Health Education Council and partners. In case of emergency I authorize my child to receive medical treatment.

Parent Signature/ Guardian _____ Date _____

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