

Free Teens 2017 Media Summit Application
April 21-23, 2017 Fairview Lake YMCA Camp, Newton, NJ

For info, visit www.FreeTeensYouth.org, call 201-488-FREE (3733) or email freeteensusa@gmail.com

Registration Deadline March 31, 2017, \$299 fee. Discounted Registration by 2/29/17, \$249 fee.

PLEASE PRINT!

Name	M/F	Age	Grade	School
Address			Town	State Zip Code
Phone (day)			Phone (evening)	Email

Does pop culture help teens to make good decisions, especially regarding sexual involvement? Explain.

(feel free to continue on back)

Why do you want to attend the Teen Media Summit? Explain.

(feel free to continue on back)

Have you made a personal decision to avoid risky behaviors such as alcohol/drug use and teen sex? _____

I. Check your choices for three of the Saturday morning workshops:

- ___ Theater Performance ___ Video Production Basics
- ___ Professional Songwriting, Recording & Producing
- ___ African Dance/Hip Hop ___ Photojournalism ___ Spoken Word

II. Choose media area you'd like to specialize in from Saturday afternoon until Sunday afternoon. Circle first choice and underline second choice.

- 1) Theater/drama 1b) Spoken Word 2) African Dance & Hip Hop**
- 3) Video Production** including filming/interviewing and editing.
 a) Music Video, b) Documentary Video, c) Message/Story Video
- 4) Song Writing, Performance and Recording; 5) Photojournalism.**

Summit Rules: Participants must follow summit schedule including curfew, to not leave Camp premises, to avoid destruction of Camp or Free Teens property, avoid any use of alcohol, illegal drugs, profanity, weapons of any kind & to refrain from romantic behaviors. Modest clothing required. No use of electronic devices such as cellphones, iPods, PSPs during Summit sessions (school rules apply).

I agree to participate fully in Summit activities, follow all rules, & understand that I could be asked to leave if I violate any of them (parents responsible to pick up child). I also understand that the Teen Summit activities will be photographed and videotaped and give Free Teens USA permission to use and reproduce recordings of my image for educational and promotional purposes.

Student Signature

Date

Any restrictions in activities? _____

continue on back if needed

Parent Program Waiver

I know of no legal, physical or health reasons why _____ cannot fully participate in the 2017 Free Teens Media Summit, except for restrictions I have listed above, and give permission for him/her to attend. I understand that if my child violates any Summit rules, I could be asked to pick him/her up early and that if my child is involved in damaging Fairview Lake Camp or Free Teens property, I could be held financially responsible. I also understand that the Teen Summit activities will be photographed and videotaped and give Free Teens USA permission to use and reproduce recordings of my child's image for educational and promotional purposes.

Registration fee \$299. Early registration fee (by 2/27) \$249.

Signature of Parent/Guardian

Registration fee enclosed _____ Check
(make check out to *Institute for Relationship Intelligence*)

Credit Card Number

Expiration Date

Name on credit card

Parent/Guardian Phone

Phone 2

Email Address

Emergency contact person

Phone

Phone 2

Make checks out to *Institute for Relationship Intelligence* or make Paypal payment to freeteensusa@gmail.com.

Mail to Free Teens 2017 Media Summit, P.O. Box 97, Westwood, NJ 07675 or fax to: 201-701-0297.

The *Free Teens Media Summit* is supported in part by grant DFHS16AEP005 from the New Jersey Department of Health, Child & Adolescent Health Program, utilizing federal funds.

Institute for Relationship Intelligence

P.O. Box 97, Westwood, NJ 07675
Tel.: 201-488-3733, Fax.: 201-701-0297

Medical Authorization Form

Medical Authorization For _____
Child's Name Date of Birth

I, the undersigned parent or guardian, having legal custody of the above-named minor, hereby authorize the staff of Free Teens USA, into whose care said minor has been entrusted, to consent to any emergency medical treatment or hospital care to be rendered to said minor upon the advice of a physician or surgeon licensed under the provision of the Medical Practice Act or by a dentist licensed under the provisions of the Dental Practice Act. I further authorize the staff of Free Teens USA to have said minor released into the custody of Free Teens USA staff, should hospital care no longer be required.

MEDICAL INFORMATION (Please mention any information that may be helpful to hospital staff if an emergency should arise)

Allergies to medication or food _____

Medication in ongoing use by child _____

Health problems (asthma, heart condition, seizures, diabetes, sickle cell, etc.) _____

Other comments _____

Child's regular clinic or doctor – Name: _____

Address: _____

Telephone Insurance Plan Membership

By my signature below, I attest the fact that all the information above is true and that I have given approval for Free Teens USA staff to provide emergency medical treatment or hospital care for my child ONLY if I cannot be reached or am unable to be contacted.

SIGNED: _____ DATE: _____
(Parent of Legal Guardian Signature)

PRINT NAME: _____ Work Tele: _____

Address: _____ Home Tele: _____

WITNESS: _____

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