

Checks can be made out to "LMTI" or "Lindsey Meyer Teen Institute"

Completed application can be sent to: LMTI, 37 Harmon Cove Towers, Secaucus, NJ 07094

1. Personal Information

First Name:		Last Name:				
Name I Prefer to Be Called (We'll use this for your nametag):		Pronouns I use (i.e. they/them, he/his, she/hers):				
Address:						
City:		State:		Zip Code:		
Home Phone:			Cell Phone (Participant):			
Participant Email Address (will be used for Registration confirmation & correspondence):						
Age:	Date of Birth:	Gender:	High School:			
T-Shirt Size (please select): Small Medium Large XL 2XL 3XL						

Post High School Plans (Check all that apply):

College (provide school and intended major):

Military (provide branch of service and any other info):

Work (provide any known details):

Trade School (provide school and area of study):

Other (time off, volunteering, etc.):

2. Health Information- The following information must be filled in by the parent/guardian if under 18. The intent of this information is to provide LMTI on site health care personnel and other authorized health care professionals with the background necessary to provide appropriate care. It is suggested you keep a copy of this for your records. Any changes to this form should be provided to the Nurse upon arrival at College Track. Rest assured that this information will only be viewed by health care professionals, as necessary.

Physician/Doctor:		Phone:
<u>Allergies</u>		
Please list ALL known including medications, food, insect stings, seasonal, etc)	<u>REACTION</u>	<u>MANAGEMENT</u>
1.		
2.		
3.		
4.		

Note Regarding Nut Allergies: The dining facilities at College Track handle and prepare peanut and tree nuts in food production areas. Nutrition and ingredient information is provided for each item, and we can provide you with a sample menu. If you have specific concerns, please let us know and we will get you in touch with the Food Manager.

Restrictions, Limitations, and Accommodations

<p>Dietary: Check all that apply</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Does not eat red meat</td> <td><input type="checkbox"/> Vegan</td> </tr> <tr> <td><input type="checkbox"/> Does not eat poultry</td> <td><input type="checkbox"/> Vegetarian</td> </tr> <tr> <td><input type="checkbox"/> Does not eat pork</td> <td><input type="checkbox"/> Gluten-Free</td> </tr> <tr> <td><input type="checkbox"/> Does not eat seafood</td> <td><input type="checkbox"/> Pescatarian</td> </tr> <tr> <td><input type="checkbox"/> Does not eat eggs</td> <td><input type="checkbox"/> Other:</td> </tr> <tr> <td><input type="checkbox"/> Does not eat dairy products</td> <td></td> </tr> </table>	<input type="checkbox"/> Does not eat red meat	<input type="checkbox"/> Vegan	<input type="checkbox"/> Does not eat poultry	<input type="checkbox"/> Vegetarian	<input type="checkbox"/> Does not eat pork	<input type="checkbox"/> Gluten-Free	<input type="checkbox"/> Does not eat seafood	<input type="checkbox"/> Pescatarian	<input type="checkbox"/> Does not eat eggs	<input type="checkbox"/> Other:	<input type="checkbox"/> Does not eat dairy products		<p>Activity: (Please explain what cannot be done, what accommodations are necessary, etc):</p>
<input type="checkbox"/> Does not eat red meat	<input type="checkbox"/> Vegan												
<input type="checkbox"/> Does not eat poultry	<input type="checkbox"/> Vegetarian												
<input type="checkbox"/> Does not eat pork	<input type="checkbox"/> Gluten-Free												
<input type="checkbox"/> Does not eat seafood	<input type="checkbox"/> Pescatarian												
<input type="checkbox"/> Does not eat eggs	<input type="checkbox"/> Other:												
<input type="checkbox"/> Does not eat dairy products													

Immunization History- Please check all immunizations that the participant has received and provide the month/year given. You may also contact your doctor's office and attach immunization records.

PLEASE NOTE: IF THIS INFORMATION IS MISSING, YOU WILL NOT BE PERMITTED TO ATTEND.

IMMUNIZATION	DATE RECEIVED	IMMUNIZATION	DATE RECEIVED
<input type="checkbox"/> Diphtheria, tetanus, pertussis (DTap) or (TdaP)		<input type="checkbox"/> Pneumococcal (PCV)	
<input type="checkbox"/> Tetanus booster (dT) or (TdaP)		<input type="checkbox"/> Hepatitis B	
<input type="checkbox"/> Mumps, measles, rubella (MMR)		<input type="checkbox"/> Hepatitis A	
<input type="checkbox"/> Polio (IPV)		<input type="checkbox"/> Varicella (chicken pox)	
<input type="checkbox"/> Haemophilus influenzae type B (HIB)		<input type="checkbox"/> Meningococcal meningitis (MCV4)	
<input type="checkbox"/> Tuberculosis (TB) test	Date:	<input type="checkbox"/> Negative	
		<input type="checkbox"/> Positive	

Medication Information

Medication- Please list ALL medications (including over the counter or nonprescription drugs) taken routinely. All medication **MUST** be kept in the original packaging/bottle that identifies the prescribing physician, the name of the medication, the dosage, and the frequency of administration. All medications **MUST** be turned into the Nurse upon arrival.

Please check one:

- This participant takes NO medications on a routine basis
 This participant takes medications as follows (continue on separate sheet if necessary):

Name of Medication	Date Started	Reason For Using It	When It Is Given	Amount or Dose Given	How It Is Given (i.e. orally)
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		

Identify any medications taken during the school year that participant may not take during the summer:

The following medications may be stocked in camp Health Center and are used on an as needed basis to manage illness and injury. **Please place a check next to any medications that should NOT be given.**

- | | | |
|-----------------------------------------------------------|-------------------|--------------------------------|
| Acetaminophen (Tylenol) | Sore throat spray | Antihistamine/Allergy Medicine |
| Diphenhydramine antihistamine/allergy medicine (Benadryl) | Antacid (Tums) | Antibiotic cream |
| Pseudoephedrine decongestant (Sudafed) | Aloe | Generic cough drops |
| Bismuth subsalicylate (Pepto-Bismol) | Calamine Lotion | Ibuprofen (Advil, Motrin) |

Additional Medical Questions (Explain all “YES” responses below)

Has/Does the participant:

Yes No

Yes No

1. Ever been hospitalized?		12. Passed out/had chest pain during exercise?	
2. Ever had surgery?		13. Had mononucleosis (“mono”) in the past 12 months?	
3. Have recurrent/chronic illnesses?		14. If female, have problems with periods/menstruation?	
4. Had a recent infectious disease?		15. Have problems with falling asleep/sleepwalking?	
5. Had a recent injury?		16. Ever had back/joint problems?	
6. Had asthma/wheezing/shortness of breath?		17. Have problems with diarrhea/constipation?	
7. Have diabetes?		18. Ever had an eating disorder?	
8. Had seizures?		19. Have any skin problems?	
9. Had headaches?		20. Traveled outside the country in the past 9 months?	
10. Wear glasses, contacts, or protective eyewear?		21. Have a peanut allergy?	
11. Had fainting or dizziness?		22. Ever been treated for emotional or behavioral difficulties?	

Please explain any “Yes” answers, noting dates and the number of the question(s): *Example: #1- hospitalized 4/07 for appendix removal*

Is there anything we should know about the participant’s mental health (include any specific diagnoses, difficulties, recent major life events)?

Is there anything else you’d like to tell us or anything we’ve forgotten to ask?



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3. Billing Information- This page **MUST** be filled out completely by you or your parent/guardian! If no billing information is provided, you and/or parent/guardian will be billed for the total tuition fee.

For All Participants: A \$25 non-refundable deposit is due with your application.

Registration Fee

The College Track tuition is: **\$375.00 (\$25 deposit + \$350 fee)**

If you would like to participate in the College Track Payment Plan, the fee schedule is as follows:

With Application: \$25 non-refundable deposit
1st Payment: \$125 due by April 30
2nd Payment: \$125 due by May 31
3rd Payment: \$100 due by June 30

Payment Options

Please select from the following:

- My full payment of \$375 (\$350 + \$25 deposit) is enclosed.

- I would like to participate in the payment plan (you will receive email reminders).

- My school or municipal alliance will pay my remaining \$350 tuition.

- I will pay the remaining \$350 in full by Friday, June 30th.

If you are unable to make the above payments due to financial hardship contact the LMTI office for more options.

Refund Policy

- ✓ A **full** refund (except the \$25 non-refundable deposit) will be given if a student drops out of, or is required to withdraw from the College Track program on or before **June 10, 2017.**

- ✓ A **partial** refund of \$125.00 will be given if the student drops out of, or is required to withdraw from the College Track program on or before **June 30, 2017.**

- ✓ No refund will be given if a student drops out of, or cannot participate in the College Track program after **July 3, 2017.**

Billing Information

Entity/Person Being Billed:		
Billing Address:		
City:	State:	Zip:
Email Address:	Phone Number:	Fax Number:

5. Parent/Guardian Consent & Release

Participant's Name:			
A. Consent for Attendance			
I, the undersigned, will attend (of if under 18, give permission for my child to attend) the LMTI College Track Conference at Montclair State University, 1 Normal Avenue, Montclair, NJ, 07043 on July 10, 11, and 12, 2017.			
B. Insurance Information			
I, the undersigned, agree to pay any medical bills (independently or through insurance) that may arise as a result of injuries incurred at the LMTI College Track Conference.			
<input type="checkbox"/> The participant is not covered by medical insurance. <input type="checkbox"/> The participant is covered by the following insurance policies (fill out or attach a copy of your insurance card):			
Insurance Company Name:		Phone Number:	
Policy Holder:	Policy Number:	Group Number:	
C. Medical Consent Emergency Contacts			
This is to certify that I, the undersigned participant or parent/guardian, hereby consent and authorize the LMTI Health Care Staff to administer medication as needed to the participant as indicated by me on Page 4 of this application. I hereby authorize trained LMTI Staff or Health Care Staff to administer first aid to the participant when necessary.			
In the event of a medical emergency, I understand that (if under 18) the parent guardian or (if over 18) the emergency contact will be contacted as soon as possible and that the participant may be transported to the nearest hospital. I give permission for the administration of all needed medicines, performance of all surgical treatment, and the administration of any anesthetic or injection which, in the opinion of the attending physician, may be necessary and advisable in the event of any medical emergencies regarding my child. It is understood that efforts shall be made prior to rendering emergency treatment to the patient. In the event that I am not available, I designate the following individuals to give further consent should it be necessary:			
Name:	Daytime Phone:	Evening Phone:	
Name:	Daytime Phone:	Evening Phone:	
D. Consent for Transportation			
I give permission for LMTI staff or volunteers to transport the participant away from the LMTI College Track Conference for any reason that is deemed necessary. I understand that in the event that the participant must return home (including psychological or physical medical needs, rule infringement, or any other occurrence deemed necessary), I am responsible for providing transportation.			
E. Consent for Photographs/Video			
I give permission for photographs/video footage to be taken of the participant, and for photographs/video footage in which the participant is included to be used for purposes of publicity by LMTI, a non-profit program. This includes publication of pictures/video on the LMTI website and LMTI social networking websites.			
F. Consent for Text Message Alerts			
I give permission for LMTI to send event and info alerts via text message to the participant via the cell phone number provided (if you do not want the participant to receive updates, please do not provide cell phone number in section 1). Standard text message rates may apply.			
G. Release, Waiver, and Indemnification			
I, the undersigned, do hereby execute this release, waiver, and indemnification and agree to represent as follows:			
The release of Montclair State University, NCADD-Hudson/Partners in Prevention, the Lindsey Meyer Teen Institute and their employees, and agents from any and all liability, loss, damage, costs, claims or causes of action including, but not limited to, all bodily injuries and property damages arising out of the sole negligence of Montclair State University, NCADD-Hudson/Partners in Prevention, and the Lindsey Meyer Teen Institute			
I further agree to indemnify and hold harmless the said above from any and all liability, loss, damage costs, or causes of action, including attorney's fees and witness costs, arising out of the undersigned participation in the Lindsey Meyer Teen Institute (LMTI) College Track Conference and other events scheduled for the 2017-2018 school year.			

6. Signatures

Participant Signature:		Date:	
Parent/Guardian Signature if under 18 :		Date:	
Parent/Guardian Name (please print):		Relationship	
Street Address:	City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:	

For additional information or questions,
please contact:



the lindsey meyer teen institute

A program of Partners in Prevention



(201) 696-0368 p

(201) 298-1618 f

info@lmteeninstitute.org

www.lmteeninstitute.org

**All completed registration materials and
payments can be sent to:**

The Lindsey Meyer Teen Institute
37 Harmon Cove Towers
Secaucus, NJ 07094

****Payments can be made out to "LMTI"****