

SOAR *for Youth*

Support, Opportunities, and Rapport

Foster Youth Summer Academies at Cal

2020 SOAR Program Application and Prepare to SOAR Academy Application

Date/Time: Sunday, July 26th 3:30pm to Saturday, August 1st 12:00pm

Location: Foothill Student Housing facility @ University of California at Berkeley, Berkeley, CA (2700 Hearst Ave. On the corner of Hearst Avenue and Gayley Road, see enclosed campus map A5-A6)

Application Deadline: Post-marked on or before **April 10th**

Youth Information

Last Name (please print)		First Name		Middle Initial	Date of Birth
Mailing Address				City	
County	State	Zip Code	Youth Home Phone Number	Youth Cell Phone Number	
Youth Email Address		Ethnicity (circle one): African American Caucasian Multiracial Latino/Hispanic Asian/Pacific Islander			
Name of School Attending		Grade Level	Grade Point Average		
Gender (circle one): Male/Female		Adult T-shirt Size (circle your size): XS S M L XL XXL			
Ability to Swim: Excellent ___ Good ___ Poor ___ Don't Know but Not Afraid of Water ___ Afraid of Water ___					
Diet limitations: Yes ___ No ___ If Yes, Explain _____					
Youth's Signature _____			Date _____		
Name of Social Worker		Phone Number	Cell Phone Number		
Social Worker's Signature		Date	Email of Social Worker		
Guardian Name		Phone Number	Cell Phone Number		
Guardian's Signature		Date	Email of Guardian		
Name & Title (affiliation) of Adult Submitting Application		Phone Number	Email Address		

Medical Release and Authorization Form

Youth's Name _____ (M/ F) Birth date _____ Age _____

Address: _____ City: _____ ZIP: _____

Name of Parent/Guardian _____ Relationship _____

Home Phone _____ Work Phone _____ Other Phone _____

Name of 2nd Parent/Guardian _____ Relationship _____

Home Phone _____ Work Phone _____ Other Phone _____

If Parent/Guardian cannot be reached in an emergency, please contact:

Alternate Contact _____ Relationship _____

Home Phone _____ Work Phone _____ Other Phone _____

Family Physician _____ Phone _____

Child's Health Insurance Co. _____ Primary member _____

Policy # _____ Address _____ City _____ Zip _____

Please list any physical or behavioral conditions that the academy staff should be aware of, (e.g. sleepwalking, diabetes, epilepsy, fainting, asthma, hyperactivity, and nosebleeds, sleep-wetting) Attach an extra sheet if necessary. Please be specific.

Is your youth allergic to any foods, medication or insect bites? (Y / N) If "yes" please specify nature of allergies.

Is your youth allergic to bee stings? (Y / N) Carrying epicene? (Y / N) Comments _____

May your youth be given non-aspirin if needed? (Y / N)

May your youth be given "over the counter" medications (listed below) if needed? (Y / N)

The following over-the-counter medications are available at the academy. It is not necessary to send these items, unless your youth uses one of them on a daily basis. Please cross out medications to be avoided.

ANALGESICS

Ibuprofen (like Advil) [tablet]

Acetomeiphan (like Tylenol) [liquid & tablet]

ANTISEPTICS

Neosporin Ointment

ALLERGY

Store-brand "Benadryl" [

INDIGESTION

Tums & Pepto Bismo

SKIN

Hydrocortisone cream

FIRST AID

Band-aids

Medication Release and Authorization Form (Continued)

Youth's Name _____

Are all immunizations current and up-to-date? (Y/N) _____ Date of last immunization _____

Date of last tetanus shot: _____ Recent surgery or illness: _____

Medication or treatment received for recent surgery or illness: _____

Please indicate any academy activities to which you will need to be exempt from.

Please list here all medication to be taken by your youth. For youth with asthma, please indicate if they have your permission to carry their inhaler with them and use their inhaler as needed, while attending the summer academy at Cal

Medication _____ Dosage _____ Condition _____

Remarks:

Medication _____ Dosage _____ Condition _____

Remarks:

Medication _____ Dosage _____ Condition _____

Remarks:

Medication _____ Dosage _____ Condition _____

Remarks:

If medication needs to be brought to the academy, all medication, both prescription and non-prescription, must be in the original container. The prescription container must be clearly labeled with the following information:

- | | |
|-------------------------------|-------------------------------|
| 1. Participating Youth's Name | 3. Name of Medication |
| 2. Physician's Name | 4. Dosage (how much and when) |

Please send enough medication for 3 extra days in case of emergency, accidental loss, or damage. Place all medication in a Ziploc bag labeled with your youth's name. Give the medication to the academy Lead Counselor. Please do not pack medicines in your child's luggage (except for inhalers, if authorized above). In the event of an emergency, every effort will be made to contact the parent or designated individual.

RESPONSIBLE ADULT AUTHORIZATION The health history provided above is correct, so far as I know, and the participating youth has permission to engage in all prescribed program activities. IN CASE OF MEDICAL or SURGICAL EMERGENCY, I authorize the academy Lead Counselor or University Housing Services person to obtain any medical or surgical care advised by a licensed health care provider. We recognize that the participating youth must follow safety instructions, remain in areas designated by staff and refrain from behavior that is harmful to him/herself or others.