TORCH of WISDOM FOUNDATION, INC

Changing Tomorrow Today™

THE LEARNING NETWORK PROGRAM APPLICATION

Students interested in participating in this program should submit the information requested below.

FIRST NAME: _____

LAST NAME: _____

DOB: ___/____/_____ (MM/DD/YY)

PARENT/GUARDIAN: _____

ADDRESS: _____

CITY_____ZIP: _____, MI _____

NAME OF SCHOOL: _____

PHONE NUMBERS:

MAIN CONTACT: _____

PARENT CELL: _____

STUDENT CELL: _____

OTHER: _____

STUDENT EMAIL: _____

PARENT EMAIL: _____

SIGNATURE_____DATE_____

COMPLETED APPLICATIONS ARE DUE APRIL 25, 2019

By email to: **programs@torchofwisdomfoundationinc.org**

In person to: Paulette Boggs or a TLN Representative

Phone: 248.252.8481

www.torchofwisdomfoundationinc.org

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Student Name: _____

Instructions: Please submit the following information with your application.

1) Submit a letter of recommendation from a school counselor, teacher, or personal referral.

2) Short Statement: Write a short statement of 50 words or less on **one** of the following statements.

a) How will *The Learning Network* Program benefit you?

OR b) What are some qualities needed to be a successful professional?

List any extracurricular activities, community involvement, or volunteer services that you participate in:

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PARENTAL/GUARDIAN
PHOTOGRAPHY AND MEDIA AUTHORIZATION FORM

1/We,_____("Parent/Guardian"), as parent(s) or legal guardian(s) of _____ give permission for The Torch of Wisdom Foundation Inc. (TOWF) to publish on the Internet or media still photographs or moving images, including, if applicable any sound recordings accompanying the images ("Images") taken of my child during participation in The Learning Network activities, without payment or any consideration and without notifying me in advance.

I/We also give permission for the TOWF to highlight my child's achievements and activities in efforts to promote the program through newspapers, radio, TV, the web, DVDs, displays, brochures, and other types of media without payment or any consideration and without notifying me.

I/We understand and agree that these Images will become the property of TOWF, which shall have complete ownership of the Images. I hereby irrevocably authorized the Foundation to publish or distribute these Images for the purpose of publicizing the program, or for any other lawful purpose. In addition, I waive any right to inspect or approve the finished product wherein my child's likeness appears. Additionally, I waive any rights to royalties or other compensation arising out of or related to the use of the Images.

I/We hereby hold harmless and release and forever discharge the TOWF and any of its officers Executive Board; representatives; and assigns from any and all claims, costs, suits, actions, judgments, and expenses which my child, his/her heirs, representatives, executors, administrators, or any other persons acting on his/her behalf have or may have by reason of the use of the Images. This release specifically includes, without limitation, a complete release and discharge of any liability by virtue of any editing, distortion, alteration, or optical illusion, whether intentional or otherwise, that may occur or be produced in the taking of or editing of said Images, unless it can be shown that such was maliciously caused, produced and published solely for the purpose of subjecting my child to conspicuous ridicule, scandal, reproach, scorn and indignity.

I/we hereby certify that I/we are the parents/guardians _____ of authorized legally to give this consent, and do hereby give my/our consent without reservation to the foregoing on behalf of my/our child.

_____ _____
Parent/Guardian Signature Date

_____
Print Name

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MEDICAL INFORMATION AND TREATMENT AUTHORIZATION PACKET

Today's Date: _____

Name of Minor: _____ Date of Birth: _____
Address: _____
City/State/Zip Code: _____
Parent/Guardian Home Phone: _____
Cell Phone: _____ E-mail Address: _____

HEALTH INFORMATION

Below please check any current health condition that may require attention during the Program day. Also complete and submit the Medication Authorization Form if your child has health conditions that require medication during the Program day.

Asthma Inhaler required at Program: ( )

Vision Problems: ( ) Glasses ( ) Contacts ( )

Hearing Problems: ( ) Hearing Aid(s) ( )

ADD/ADHD: Yes ( ) No ( )

Other: _____

Allergies/Sensitivities (be specific)

Foods _____

Medicines _____

Bee sting or insect bite _____ Other _____

List all medications and dosages your child receives on a continual basis, that must be taken during program's

Child's Name (Last, First, M.I.): _____

Gender Recognition (check one): Male ( ) Female ( )

Is/Has child been under the regular supervision of a physician? Yes ( ) No ( )

Name, address, and phone number of physician _____

_____

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Health and Developmental History:

Does child have any significant health history, conditions, communicable illness, or restrictions that may affect child's participation in The Learning Network program?

(Check one) None ( ) Yes ( )

If yes, please provide detailed explanation_____

_____

_____

Does child have any significant food/medication/environmental allergies that may require emergency medical care? Yes ( ) No ( ) (Check one)

If yes, please provide detailed explanation_____

_____

Specify any other serious or severe illnesses or accidents:_____

_____

Does child take prescribed medications? Yes ( ) No ( )

Name the medications: _____

For any medications or treatment required during the course of the TLN program, a Medication Authorization Form should be completed and submitted with this form.)

Does child take any over the counter medications frequently? Yes ( ) No ( )

Name of the medications:_____

Frequency Taken:_____

NON-PRESCRIPTION MEDICATION PERMIT

PLEASE CHECK those medications you give permission for your child to receive (generic equivalent may be used). I/We understand that medications will be administered with discretion by an authorized Program employee and in accordance with established protocols developed by the Program.

The following nonprescription medications may be available to your child:

( ) For headaches/fever/muscle aches/pain/cramps: Acetaminophen (e.g., Tylenol, including Junior Strength), Ibuprofen (e.g., Advil, including Children's liquid, Motrin), Naproxen (Aleve), Midol, & Excedrin.

( ) For bites/allergic rashes: Anti-itching lotion (e.g., Calamine or Hydrocortisone cream 1 %), Benadryl liquid or capsules.

( ) For nasal congestion/sinus pressure: Decongestant

( ) For sore throat: Throat lozenges (e.g., Capitol lozenges)

( ) For coughs: Cough drops/lozenges or cough suppressant.

( ) For upset stom`ach: Antacid liquid or chewable tablets (e.g., Mylanta) For sun protection: Sunscreen lotion SPF 30.

( ) I DO NOT WANT ANY MEDICATIONS GIVEN TO MY CHILD.

Parent/Guardian Signature_____Date_____

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PHYSICIAN & INSURANCE INFORMATION

Name of Child's Physician _____ Phone _____
Health Insurance Company _____ Phone _____
Policy Number _____ Group Number _____
Insurance Company Address _____
City/State/Zip Code _____
Name of Policy Holder

_____
Name of Policy Holder's Employer _____

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PARENTAL/GUARDIAN AFFIRMATION

I, (Parent/Guardian) _____ hereby give my permission to the Torch of Wisdom Foundation, Inc., for _____to participate in The Learning Network (including all planned activities), and I hereby attest, under penalty of perjury, that I have the legal authority to authorize such participation.

Printed Name: _____

Signature: _____

Relationship to child: _____ Date: _____

WAIVER AND RELEASE

I, (Parent/Guardian) _____ on behalf of

_____ ("Participant Minor Child") do hereby release, waive, discharge, covenant not to sue and agree to hold harmless The Torch of Wisdom, Incorporated ("TOWF"), its officers, National Executive Board, employees, members, volunteers and/or representatives, agents, affiliates, and assigns (collectively "Releases"), from any and all claims, demands, and actions of any and every kind directly or indirectly arising out of, or relating in any respect to Participant Minor Child's participation in the The Learning Network. My waiver and release of all claims, demands, actions, and liability shall include without limitation, any injury, illness, death, property damage or loss to the Participant Minor Child which may be caused by any act, or failure to act, by the Releases, unless such injury, illness, death, property damage or loss is a direct result of the willful misconduct of any Releases. I understand that, without limitation of the foregoing, neither The Torch of Wisdom, nor the Program, shall be liable and each is hereby released from all claims that may arise from loss or damage to the Participant Minor Child's personal property.

Parent/Guardian Signature: _____ Date: _____

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TRANSPORTATION PERMISSION SLIP

I, (Parent/Guardian)_____ give my permission to The Learning Network (TLN) program of the Torch of Wisdom Foundation to transport my child, _____ (name of child or children) to and from TLN session on Saturday, _____ _ to _____ located at _____ in _____. MI.

____I give permission for a TLN volunteer to drive my student in their personal vehicle in the event the van capacity is exceeded.

TLN students will depart from the TOWF at 8:40am with a planned arrival of 9:00am at the session site. Departure from the facility will be at 3:00pm with a planned return to the TOWF facility of 3:30pm.

During these activities I may be reached at:
Priority Phone #_____
Mobile Phone#_____
If I cannot be reached in the event of an emergency, the following person is authorized to act on my behalf:
Name_____ Phone_____
Relationship to participant_____
Other comments_____
_____
Signature of parent/legal guardian_____