

The K.R.U.N.K. Movement

(download this application and email completed form to smithcol@verizon.net)

Name _____ Nickname _____ School _____
Male Female Year _____ Age _____ Date of Birth _____
Address _____ City/State _____ Zip _____
Home Phone # _____ Email: _____ SS# _____

Emergency Contacts

Name _____ Day time Phone _____
Address _____ City/State _____ Zip _____
Name _____ Day time Phone _____
Address _____ City/State _____ Zip _____

Area(s) of Interest (check all that apply)

Rapper/Writer Beat Maker/Technician Dancer Visual Artist

Health Information

Name of Primary Care Physician _____ Phone# _____
Address _____
Health Insurance Provider _____ Policy# _____
Special Needs or Disabilities _____ Allergies _____
Dietary Needs _____

If you are currently taking any medications please list them all.

I recognize that the staff of Center Of Life will take every precaution to guarantee my safety. However, in the event of an emergency I hereby give my permission for attending staff, or volunteer, to seek medical attention on my behalf, and I further agree to take responsibility for any resulting financial obligations. I also authorize the use of photographs taken of me for the sole purpose of Center Of Life programs only.

Signature of Applicant

Date