

# APTC WINTER 2012

## Contact and Medical Insurance Information

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FIRST NAME      MI      LAST NAME      T-SHIRT SIZE (INDICATE MEN'S/WOMEN'S)

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PREFERRED NAME      DATE OF BIRTH      PARTICIPANT'S EMAIL ADDRESS

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HOME ADDRESS

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CURRENT GRADE      NAME AND ADDRESS OF SCHOOL

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PARENTS' HOME PHONE      PARENTS' EMAIL ADDRESS

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MOTHER'S NAME      OCCUPATION      BUSINESS PHONE      CELL

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FATHER'S NAME      OCCUPATION      BUSINESS PHONE      CELL

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IF PARENTS DO NOT LIVE TOGETHER, WITH WHOM DOES PARTICIPANT LIVE?

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NAME AND ADDRESS OF NON-CUSTODIAL PARENT

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HOW DID YOU HEAR ABOUT APTC? (PLEASE PROVIDE THE NAME/S OF THE INDIVIDUAL OR OTHER SOURCE OF REFERRAL.)

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PLEASE LIST ANY MEDICAL CONDITIONS, ALLERGIES, ETC. OF WHICH WE SHOULD BE AWARE OR WHICH WOULD BE NECESSARY FOR MEDICAL PERSONNEL IN THE CASE OF EMERGENCY. USE BACK IF NECESSARY.

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MEDICAL INSURANCE PROVIDER AND POLICY NUMBER FOR PARTICIPATING STUDENT.

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GROUP NUMBER AND/OR EMPLOYER NAME, IF APPLICABLE

PLEASE PROVIDE TWO ALTERNATE EMERGENCY CONTACT PERSONS.

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NAME	RELATIONSHIP	HOME PHONE	WORK OR CELL PHONE
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