



Summer PROGRAM

YOUTH LEADERSHIP CONFERENCE, FIELD TRIPS,
WORKSHOPS, AND COMMUNITY SERVICE PROJECTS



SUMMER SCHEDULE

JUNE 25-27: YOUTH LEADERSHIP CONFERENCE

JULY 22-26: SUMMER 4 KIDS WEEK 1 9:00-4:00

AUGUST 5-9: SUMMER 4 KIDS WEEK 2 9:00-4:00

AUGUST 19-23: SUMMER 4 KIDS WEEK 3 9:00-4:00

DATES TBD: MINER'S BASEBALL GAME, TURTLEBACK
ZOO, & APPRECIATION DINNER

OPEN TO ALL INCOMING 6-9TH GRADERS

**FREE TO ALL PARTICIPANTS!
SPACE LIMITED**



REGISTER WITH MICHAELA
MICHAELA@CENTERFORPREVENTION.ORG





Above the Influence Summer Permission & Release Form

A program of the Wallkill Valley Community Coalition and Center for Prevention and Counseling

Contact Michaela at michaela@centerforprevention.org

Today's Date _____

Student's Name _____ Parent's Name _____

Street Address _____ Mailing Address _____

City _____ State _____ Zip _____

Current School/ Grade _____ Date of Birth _____

Student's Email: _____ Cell # _____

T-Shirt Size: _____ Parent/Guardian Email _____

Cell # _____ Parent/Guardian Home # _____

Work # _____

Emergency Contact Name _____ Phone # _____

Medical Conditions—Allergies, chronic conditions, other: _____

Medications: _____

I hereby grant permission for my child to participate with The Above the Influence Youth Group, a program of the Wallkill Valley Coalition & the Center for Prevention & Counseling. I understand that my child participates in these activities at their own risk and that THE WALLKILL VALLEY COMMUNITY COALITION and/or the Center for Prevention and Counseling and its adult supervisors are not liable for any injury personal or otherwise to my child or caused by my child. Should any problems arise concerning the behavior of my child, I will come pick my child up. I recognize that THE WALLKILL VALLEY COMMUNITY COALITION uses photographs and video images of events for publicity materials such as THE WALLKILL VALLEY COALITION and CFPC website, newspapers, newsletters, Facebook pages, Instagram and local televised media and I hereby grant permission for photo/video images of my child to be taken and used for such purposes. I authorize the treatment, by a qualified and licensed medical doctor, of the minor listed above in the event of any medical emergency which, in the opinion of the attending physician, is necessary and I/we cannot be reached after reasonable effort has been made to secure my personal consent. I am responsible for any medical expenses.

Signed: _____
(Parent or legal guardian)

Date: _____

