



# ♀ SISTERS OF SUMMER

HIGH SCHOOL GROUPS  
9-12TH GRADE

JUNE 13 - 17  
10 AM - 2 PM

SPACE IS LIMITED.  
CALL 515.244.4901  
OR GO TO [YWRC.  
ORG/PROGRAMS/](http://YWRC.ORG/PROGRAMS/)  
SUMMER TO  
REGISTER.

TOPICS INCLUDE:  
FEMINISM,  
SELF-EXPRESSION,  
BODY POSITIVITY, &  
REPRODUCTIVE JUSTICE

★ **FREE PROGRAM!**

(LUNCH + TRANSPORTATION PROVIDED)



## YWRC Summer Program Registration Form

Please fill out the attached registration form and return to your group leader, fax to our office at 515-243-5073, send a scanned copy to empowerment@ywrc.org, or deliver to our office at 818 5th avenue, DSM, IA, 50309

**Please indicate with an "x" which session the participant will attend below:**

Sisters of Summer	(Going into 9 <sup>th</sup> – 12 <sup>th</sup> grade)	____ June 13 <sup>th</sup> -17 <sup>th</sup>		
Sisters of Summer	(Going into 7 <sup>th</sup> /8 <sup>th</sup> Grade)	____ June 20 <sup>th</sup> -24 <sup>th</sup>	<b>OR</b>	____ July 11 <sup>th</sup> -15 <sup>th</sup>
Movin' Onto Middle School	(Going into 6 <sup>th</sup> Grade)	____ June 27 <sup>th</sup> – July 1 <sup>st</sup>	<b>OR</b>	____ July 18 <sup>th</sup> -22 <sup>th</sup>

Participant's Name \_\_\_\_\_ Birthday \_\_\_\_\_ Age \_\_\_\_\_

School \_\_\_\_\_ Grade going into \_\_\_\_\_

Caregiver/Guardian's Name \_\_\_\_\_

Caregiver/Guardian's Email \_\_\_\_\_

Caregiver/Guardian's Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Gender: \_\_\_\_ Cis Female \_\_\_\_ Trans Female \_\_\_\_ Non-Binary \_\_\_\_ Other Gender(s) \_\_\_\_\_

Race: \_\_\_\_ Black/African American \_\_\_\_ Asian \_\_\_\_ Native Hawaiian/Other Pacific Islander

\_\_\_\_ White/Caucasian \_\_\_\_ American Indian/Native Alaskan \_\_\_\_ Other/Multiple Races

Is the participant Latina? \_\_\_\_ Yes \_\_\_\_ No

Does the participant utilize the free/reduced lunch program? \_\_\_\_ Yes \_\_\_\_ No

**\*Transportation:** the participant must be within a 7-mile radius of the YWRC to receive transportation

Does the participant need a ride to the **YWRC** for the group? Yes \_\_\_\_ No \_\_\_\_

Does the participant need a ride **home** from group? Yes \_\_\_\_ No \_\_\_\_

Pick up/Drop off address: \_\_\_\_\_ **OR** Same as above \_\_\_\_\_

I give my child permission to attend the YWRC Programs and any field trips planned and will allow my child to be transported by YWRC Staff/Volunteers.

I understand that the YWRC is not responsible for any stolen or lost personal belongings. In the event of accident, injury, or sudden illness and I cannot be reached; I give my consent for the YWRC staff to secure proper medical treatment. I agree to be responsible for all medical expenses.

I give permission to the YWRC to use any photographs or video tapes taken of my child while participating in the program to use for promotional activities of the program or school. Yes \_\_\_\_ No \_\_\_\_

Staff from the Center may contact you or your student for follow-up through her high school graduation. If you do not wish for us to do so, please check here \_\_\_\_.

YWRC conducts periodic surveys with our clients to measure progress and to make program quality improvements.

Caregiver/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Medical/Emergency Information

I assume all responsibility for any accidents or injuries that may occur, and release the facilitators and Young Women's Resource Center employees of all liability. In case of accident, injury or sudden illness and I cannot be reached, I request that necessary medical care be instituted. Our physician/dentist may be contacted in case of medical treatment or as necessary and is authorized to release requested information as needed. The caregiver/guardian is responsible for all medical expenses.

Participant's Name \_\_\_\_\_  
Doctor \_\_\_\_\_ Phone \_\_\_\_\_  
Dentist \_\_\_\_\_ Phone \_\_\_\_\_  
Hospital Preference: \_\_\_\_\_

### Emergency Contacts

Name \_\_\_\_\_ Relationship with child: \_\_\_\_\_ Phone Number \_\_\_\_\_  
Name \_\_\_\_\_ Relationship with child: \_\_\_\_\_ Phone Number \_\_\_\_\_  
Does the participant have any allergies? Yes \_\_\_\_\_ No \_\_\_\_\_  
If Yes, what? \_\_\_\_\_

Medication\* (Please list name and dosage)

\_\_\_\_\_

\_\_\_\_\_

\*Note: Staff is unable to administer medication. This information is for emergency personnel only.

Health Concerns

\_\_\_\_\_

\_\_\_\_\_

Health Insurance \_\_\_\_\_ Insurance Number \_\_\_\_\_

**I have answered these questions to the best of my knowledge. If I have any questions or concerns, I will speak with the program facilitator.**

Print Name \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**If you have any questions or need assistance please contact the YWRC at 515.244.4901  
Visit our website at [www.ywrc.org](http://www.ywrc.org) to learn more about our programs & staff.**