



YouthWorks: Emergency and Contact Information

Northwest Youth Corps

2621 Augusta Street, Eugene, OR 97403

Phone: (541) 349-5055 • E-mail: jobs@northwestyouthcorps.org

Name: _____ Male Female

Age: Date of Birth: / /

Mailing Address: _____
Number Street City State Zip County

Phone: () - E-mail: _____

Emergency Contact Information

List three separate contacts who each live at three different addresses (relative, neighbor, family friend, etc.). We require day and evening phone numbers. In an emergency, NYC field staff will make every effort to call contacts in the order listed.

Contact 1 (required) If you live here, please check:

Name: _____ Day/Work Ph.: _____

Relationship: _____ Evening/Home Ph.: _____

Address: _____ Cell. Ph.: _____

City, State, Zip: _____ Employer: _____

E-mail Address: _____ Occupation: _____

Example:

Contact 1:
Angela Smith
mother
123 Maple Lane,
Albany, OR 97321
E-mail: stories@netzero.net
Day: 541-111-0000
Eve: 541-111-0000
Cell: 503-444-8888

Freelance writer

Contact 2 (required) If you live here, please check:

Name: _____ Day/Work Ph.: _____

Relationship: _____ Evening/Home Ph.: _____

Address: _____ Cell. Ph.: _____

City, State, Zip: _____ Employer: _____

E-mail Address: _____ Occupation: _____

Contact 2:
Rene Richmond
aunt
456 Oak Street
Albany, OR 97321
E-mail: rener123@msn.com
Day: 541-222-3333
Eve: 541-222-6666 x123
Cell: -----
Green Manufacturing
Production Manager, shift 2

Contact 3 (required) If you live here, please check:

Name: _____ Day/Work Ph.: _____

Relationship: _____ Evening/Home Ph.: _____

Address: _____ Cell. Ph.: _____

City, State, Zip: _____ Employer: _____

E-mail Address: _____ Occupation: _____

Contact 3:
Joe Mendoza
family friend
789 Pine Road
Tigard, OR 97223
E-mail: joem@xyzcenter.com
Day: 503-333-4444 x456
Eve: 503-333-7777
Cell: 503-555-9999
XYZ Medical Center
Registered Nurse

Medical Information

Insurance Information (provide a copy of your card)

Do you have health or accident insurance? Yes No

If yes, list name of insurer: _____

Insured's Name: _____ Group/Policy Number: _____

Allergies

List **allergies to medications** (e.g., aspirin, penicillin) as well as your reaction: _____

List **other allergies and reactions** (e.g., bee stings, peanut butter): _____

Immunizations

All youth above the age of 12 are required to have a primary MMR (Measles, Mumps, Rubella) vaccination and a booster. Have you had these vaccinations?: Yes No

Date of last Tetanus shot: _____

If you have not had a tetanus shot in the last five years, we recommend that you get one prior to starting NYC.

Current Medical Condition

If you are currently under a doctor's care, please list condition, doctor's name, address, fax, and phone number:

Doctor: _____ Fax: _____ Phone: _____

Do you have any current medical problems (e.g. ear infection, sore throat)? If yes, please specify: _____

If you are currently taking prescription or over-the-counter medications please list:

Name of medication	Dosage amount	How many times a day?
_____	_____	_____
_____	_____	_____

If taking meds, do you self-medicate? (Please call for a form if you take meds during program hours) Yes No

Have you been exposed to any contagious diseases in the past two weeks? Yes No

Have you been, or are you now, under the care of a counselor? Yes No

If yes, describe your condition and dates of therapy: _____

Please check and list dates for current or past conditions.

✓ Date	✓ Date	✓ Date
<input type="checkbox"/> _____ Back injury	<input type="checkbox"/> _____ Tobacco use	<input type="checkbox"/> _____ Heart disease
<input type="checkbox"/> _____ Broken bones	<input type="checkbox"/> _____ High blood pressure	<input type="checkbox"/> _____ Hepatitis
<input type="checkbox"/> _____ Carpal tunnel	<input type="checkbox"/> _____ Migraine headaches	<input type="checkbox"/> _____ Kidney disease
<input type="checkbox"/> _____ Knee injury	<input type="checkbox"/> _____ HIV positive	<input type="checkbox"/> _____ Liver disease
<input type="checkbox"/> _____ Head injury	<input type="checkbox"/> _____ AIDS	<input type="checkbox"/> _____ Lung disease
<input type="checkbox"/> _____ Hearing problems/deafness	<input type="checkbox"/> _____ Anemia	<input type="checkbox"/> _____ Thyroid disease
<input type="checkbox"/> _____ Vision/wear glasses or contacts	<input type="checkbox"/> _____ Asthma	<input type="checkbox"/> _____ Venereal disease
<input type="checkbox"/> _____ Chemical addiction	<input type="checkbox"/> _____ Cancer	<input type="checkbox"/> _____ Pregnancy
<input type="checkbox"/> _____ Depression	<input type="checkbox"/> _____ Diabetes/hypoglycemia	<input type="checkbox"/> _____ Other _____
<input type="checkbox"/> _____ ADD/ADHD	<input type="checkbox"/> _____ Epilepsy/seizure disorder	_____
<input type="checkbox"/> _____ Emotional disorders	<input type="checkbox"/> _____ Gastric ulcers	_____

Describe diagnosis/status of the current conditions checked above: