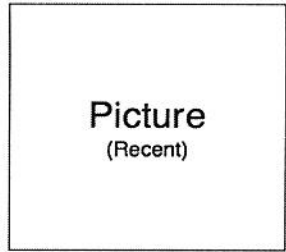


Eta Nu Chapter of Omega Psi Phi Fraternity, Inc.
 Eta Nu Education Foundation, Inc.
 Mentoring Program



Circle One:

- o G.O.I.(Gentlemen of Influence) (Ages 15-18yrs)
- o Q Unit (Ages 10-14yrs)



Our Mission:

To provide young males with the guidance and support needed to reach their full potential by developing the necessary skills to be successful. We will further seek to inspire and enable young males to be caring, responsible, and productive people to their community and society.

First Name of Child	Last Name of Child	Birth Date
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Child's Email Address	Child's Cell Phone
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School	Grade	Grade Point Average(GPA)
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First Name of Parent(s)/Guardian(s)	Last Name	Relationship to Child
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Phone Number (Cell/Home/Work)	Email Address
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First Name of Parent(s)/Guardian(s)	Last Name	Relationship to Child
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Phone Number (Cell/Home/Work)	Email Address
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Home Street Address	Apartment Number
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City	State	Zip Code
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Emergency Contacts (other than parent & guardian):

1. _____
Name Phone Relation to Child

2. _____
Name Phone Relation to Child

Medical Insurance Information

Name of Child's Physician Physician Phone Number

Insurance Company Policy/Group Number

Name of Primary Member Medicaid Number

Does your child currently have any health concerns? Please check from list below:

- | | | |
|--|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Lyme disease | <input type="checkbox"/> Ears, Nose, Throat | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hearing impairment |
| <input type="checkbox"/> Digestion | <input type="checkbox"/> Braces | <input type="checkbox"/> Sickle Cell |
| <input type="checkbox"/> Glasses/contacts lenses | <input type="checkbox"/> Lungs | <input type="checkbox"/> Other _____ |

If you checked any of the above, please explain: _____

Any restrictions or special accommodations needed during activities for medical reasons?

- Yes No

If YES, please explain: _____

Allergy Information

Please mark appropriate box based on you child's allergies.

Any medication Yes No If yes, what _____

Bee stings, insect bites or plants Yes No If yes, what _____

Food Yes No If yes, what _____

Latex Yes No If yes, what _____

Other Yes No If yes, what _____

If your child does have allergic reactions, please answer the following questions:

- Can your child have a reaction just from being near the allergen (inhaled), or does he have to touch or ingest it? _____
- Please describe what happens to your child if exposed to each allergen:

- Does your child feel the allergic reaction coming on? _____
- What do you give your child if he has a reaction? _____

Media Release

Eta Nu Chapter of Omega Psi Phi Fraternity, Inc.

Eta Nu Education Foundation, Inc.

Mentoring Program

I hereby grant to The Mentoring Program of Eta Nu Education Foundation, Inc. ("Eta Nu Chapter of Omega Psi Phi, Inc."), or any of its agents, the right and permission, in respect of the photographs and video which The Education Foundation, Inc or its agents have taken of me or my children, or in which I/we may be included with others, to copyright the same in its own name or otherwise; to use, reuse, publish and re-publish in the same in whole or in part, in conjunction with any printed matter in any and all media now or hereafter known, and for any purpose whatsoever, for illustration, promotion, art, advertising and trade, or any other purpose; and to use my name, my children's names, and any statement made by me or my children, in connection therewith if The Eta Nu Education Foundation, Inc so chooses.

I have read the foregoing and fully understand the contents hereof. This release shall be binding upon me and my heirs, legal representatives and assigns.

Signature of Parent or Guardian

Date

I hereby agree to all of the above authorizations and permissions.

Signature of Parent or Guardian

Date