Inner-City Youth Development
ACT Prep & Test Taking Skills Workshop
Permission Form

Workshop Session ___**1.** ___**2.** ___**3.**	**Date Received:** ______________
Paid: Cash ________ **Check** ___________	**Amount Paid** _______________

Vicksburg __ Warren Central __ St. Aloysius __ Porters Chapel __

Check the school system that you attend.

Date: ____________________________ [ ] Male [ ] Female

Name of Youth: ______________________________________ Age: __________

{Please Print}

Parent Name: ____

Address: ______________________________ City ___________________ Zip ________

Home Phone: ____________________ Work Phone: __________________ Ext. _____

Fax: _____________________________ Cell Phone: ____________________________

Medical Information

The following information pertains to any special medical needs' and/or information critical to your child's well-being. Please use this space to note allergies, asthma condition, food problems, or emotional needs beyond normal.

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____

Doctor's Name ___________________________ Phone ( ) - ________________

I hereby give my child permission to participate in the Workshop in which I have chosen. I release anyone connected with the **City of Vicksburg** and **Alcorn State University** of all personal or public liability resulting from my child's participation.

________________________________ ____________________________

Parent/Guardian Print Parent/Guardian Signature