

University Of West Florida
College Reach-Out Program (CROP)
SUMMER Residency Program
Student Application

DATE: _____

UWF _____ PJC _____ OWCC _____

DEMOGRAPHIC INFORMATION		
NAME:	BIRTHDATE:	
STREET ADDRESS:	SSN#	
CITY/STATE/ZIP:		
GENDER:	RACE:	HOME PHONE:
GRADE:	SCHOOL:	AGE:

FAMILY INFORMATION	
FATHER'S NAME:	
ADDRESS:	
HOME PHONE:	WORK PHONE:
MOTHER'S NAME:	
ADDRESS:	
HOME PHONE:	WORK PHONE:
If you do not live with your parents, please list your guardian's name and phone number.	
GUARDIAN'S NAME:	PHONE NUMBER:
EMERGENCY CONTACT:	PHONE NUMBER:

SPECIAL MEDICAL INFORMATION PERTAINING TO THE STUDENT:

Medication: _____ Special Diet _____

Medical Needs: _____ Other: _____

Physician: _____ Phone # _____

Hospital _____

Insurance / Medicaid: _____ **(For out of town medical emergency ONLY)**

AUTHORIZATION:

I hereby certify the information on this application is true to the best of my knowledge. I give authorization for my child to participate in CROP. I assume full responsibility for his or her conduct in College Reach-Out Program. I understand that my child may be dismissed from the Summer Program if disciplinary or other violations occur. I understand that my child will reside on campus at UWF if selected for the residency program. My child can participate in ALL activities and related trips requiring transportation.

PARENT & STUDENT SIGNATURES:

PARENT or GUARDIAN SIGNATURE

DATE

STUDENT SIGNATURE

DATE

IMPORTANT: PLEASE COMPLETE ALL AREAS OF THIS APPLICATION.