

# PROGRAM APPLICATION

EDWARDSVILLE POLICE DEPARTMENT

# Summer Youth Academy



June 1-12, 2026

8 a.m. to 4 p.m. Monday-Friday

St. Mary's Catholic School

Open to ages 12-16

Cost: \$100



## PARTICIPANT INFORMATION:

LAST NAME FIRST MIDDLE INITIAL

STREET ADDRESS

CITY ZIP

HOME PHONE \_\_\_\_\_

EMERGENCY PHONE \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_

SEX \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

GRADE \_\_\_\_\_ (to assist in team assignments)

T-SHIRT SIZE: ADULT SIZES (CIRCLE)

SMALL MEDIUM LARGE EXTRA-LARGE

SHORTS SIZE: ADULT SIZES (CIRCLE)

SMALL MEDIUM LARGE EXTRA-LARGE

PARENT OR GUARDIAN NAME (please print)

AGREES TO PERMIT:

ACADEMY PARTICIPANT NAME (please print)

To participate in the Edwardsville Police Youth Academy, I hereby release of all liability the City of Edwardsville, its elected officials, employees and academy host site and its employees of any illness, injury, physical or emotional, that may result from participation in the Youth Academy.

PARENT/GUARDIAN SIGNATURE

DATE

## HEALTH AND MEDICAL INFORMATION:

If you answer yes to any of these questions, please explain carefully.

Does the academy applicant have any special challenges? For example: visually or hearing impaired, learning disability, behavioral disorder, etc.? If so, please explain: (Use additional paper, if necessary)

Does the academy applicant have any known allergies or take allergy medication? YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, please list below: (Use additional paper, if necessary)

Does the academy applicant have any of the following conditions for which he/she is currently or has been previously under medical care?

\_\_\_ ASTHMA                      \_\_\_ DIABETES  
\_\_\_ EPILEPSY                    \_\_\_ HYPERACTIVITY  
\_\_\_ HEART DISEASE            \_\_\_ RESPIRATORY PROBLEMS

Any other conditions or health concerns not listed above? Please describe: (Use additional paper, if necessary)

Is the applicant taking any prescribed medications for above listed conditions? YES \_\_\_\_\_ NO \_\_\_\_\_

IF YES, MEDICATION(S):

DOSAGE: \_\_\_\_\_ WHEN TAKEN: \_\_\_\_\_

FAMILY DOCTOR: \_\_\_\_\_

PHONE: \_\_\_\_\_

FAMILY DENTIST: \_\_\_\_\_

PHONE: \_\_\_\_\_

The Edwardsville Police Department, its agents and its employees are hereby granted permission to secure such medical aid and hospital services that the Youth Academy staff deem necessary for the person noted on this medical release form, if he/she were to sustain an injury or illness during the academy program. I have indicated all health concerns and medical information that the Youth Academy staff should be aware of regarding the above stated academy applicant's physical and mental well-being.

SIGNATURE OF PARENT/GUARDIAN

DATE

If paying by check, make it payable to Edwardsville Police Youth Academy and mail or drop off with this application to:

Edwardsville Police Youth Academy, Attention: Officer Ryan Grimes  
Public Safety Building, 333 S. Main Street, Edwardsville, IL 62025