



KING'S KIDS

PUERTO RICO

A Ministry of Youth With A Mission

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NIKO

Dear Applicant,

We are very pleased that you are interested in participating in our 5 days of surviving in the NIKO, sponsored by King's Kids of Puerto Rico, a ministry of Youth with a Mission, to take place from **March 26 to March 31, 2010**.

We believe that youth play an important role in completing God's plans in this century. We are seeking young people who genuinely want to know God better and love Him with all their hearts.

This is not a time for just having fun or entertainment. NIKO is a camp directed at developing Christian character, knowing God in an intimate way to make him know to others and knowing yourself better. In order to accomplish our objectives we run a very rigorous schedule. We rise very early and each hour of the day is regulated by a strict schedule.

We are sending you the application so that you can complete and submit it as soon as possible to the address indicated above. The following forms are part of the NIKO application:

- 1- Health History
- 2- Medical Exam
- 3- Signed Consent Forms

Applications are handled as follows:

1. Submit your completed application with Health History and signed Consents. Incomplete applications will not be considered.
2. Once you've received notification that you've been accepted send a deposit of \$50.00 dollars. The cost of the camp is **\$ 150.00** dollars and the remainder is due at registration on the evening that the camp starts.

The NIKO camp starts at Friday on **March 26, 2009** at 6:00 P.M. It will be five challenging and intense days dedicated to spiritual teaching, developing decision making skills, teamwork and serving others.

We look forward to hearing from you. God Bless You!

In His service,

Lyssette Ruiz
Directora de King's Kids P.R.

PERSONAL INFORMATION

PHOTO 2X2

Name _____ Sex _____
First Name Last Names

Address: _____

Telephone () _____ () _____ City, State Zip Code
Residence Cellular phone E-mail: _____

Date of Birth _____ Birth Place _____ Age _____
Month/Day/Year City State Country

Citizenship _____ Visa Number _____ Country _____

Passport Number _____ Expedition _____ Expiration _____

Marital Status: Single Engaged Married Divorced

T-Shirt/Polo Size young: __8-10 __10-12 __14-16 adult: __S __M __L __XL

PERSONAL

YWAM Operates as a family. For this reason we do not permit relationships that are romantic in nature. Do you accept this rule? Yes No

YWAM reserves the right to refuse acceptance on the basis of noncompliance of the rules set by the organization. Cellular telephones and Beepers are not permitted.

EMERGENCY CONTACT

Name _____ Relationship _____
First Name Last Name

Address: _____

Phone () _____ () _____ () _____ Country Postal Code
Home Cellular phone Work

CHURCH INFORMATION

Name of the Church you attend _____

Address: _____

Pastor's Name _____ Phone _____

How long have you attended? _____

EDUCATION

Grade _____ School _____ Phone _____

School Principal _____ Languages: _____

Abilities and talents: __music __dance __theatrical __sports __first aids __other: _____

PREVIOUS EXPERIENCE IN YWAM OR KING'S KIDS

Have you ever participated in any missionary outreach, any Youth with a Mission or King' Kids Program?

____Yes ____No Specified: Niko____ DTS ____ King's Kids Training____ When? _____

Where? _____ Leader's Name: _____

How you know about this training? Who referred you? _____

SELF EVALUATION

We would like to know what you think about yourself: You are

Talkative /Frank Friendly/Extroverted Very Quiet Shy Loner

Most mornings I wake up:

With a lot of energy Happy Various moods Irritable Grouch

When my mother asks me to do something:

I do it and ask what else I can do. I do it right away. I finish what I'm doing then I do it.

I say I'll do it but then I forget to. I ask "Why do I have to?"

Generally I keep my room:

Immaculate Clean but comfortable Somewhat disorderly Disaster Zone

If something I was hoping for doesn't happen I:

Pretend it was not important I get angry but it passes quickly I complain I feel bad for a long time

If I could change anything in my life I would change

Health History

(To be completed by the Applicant)

Name: _____

Weight: _____ Height : _____

Primary Physician: _____ Phone : _____

Primary Health Insurance: _____ Account Number: _____

Please answer **Yes** or **No** to the following questions. Answers will be strictly confidential.

1- Are you in good health? Yes No

2- Are you under medical treatment? Yes No

If yes, specified your condition and treatment _____

3- Do you or have you had any of the following? (Mark with a **P**)

- | | |
|--|---|
| <input type="checkbox"/> Artificial Valves or defective Valves | <input type="checkbox"/> Wets itself in bed |
| <input type="checkbox"/> Congenitive Heart Disease | <input type="checkbox"/> Skin eruptions |
| <input type="checkbox"/> Cardiovascular illness, Heart attacks | <input type="checkbox"/> Convultions |
| <input type="checkbox"/> Chest pains during excercise | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Hepatitis Type?: _____ |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Allergies Explain : _____ | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Gastritis |
| <input type="checkbox"/> Problems with Kidneys | <input type="checkbox"/> Dizzy Spells |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Abdominal Pains |

Bruise easlily

Special Diet Explain: _____

Asthma

Get fatigue when excersise

4- Do you use any of the following:

Special Shoes Hearing Aides Others : _____

5- Do you exercise? Yes No What type? : _____ Frequency _____

6- Are you taking any of the following medications? (please mark with a **II**)

Antibiotics Tranquilizers Medicine for the pressure

Cortisone Aspirin Insulin

Others : _____

7- Are you allergic to some of this medications? (please mark with a **II**)

Insulin Aspirin Codine Penicilin

Antibiodics specify : _____ Others: _____

8- Blood type : _____

9- Women Only: Are you Pregnant? Yes No Do you have problems with your menstrual cycle? Yes No

Do you take birth control pills? Yes No Are you takin medication for menstrual pain? Yes No

Specify: _____

10- Do you have any medical condition not mentioned that requires regular medical treatment? Yes No

Explain _____

I certify that the information that I provided is correct and for my own benefit and that this information will be strictly confidential to be used by the Youth With A Mission staff. If I omit information or state information that is false I will not hold Youth With A Mission or its staff responsible for any damage or disciplinary action deemed necessary. Youth With A Mission reserves the right for admision or suspension if you do not meet these requirements.

Applicant Signature / Date

Parent/Guardian Signature / Date

FAMILY FACTS

The following questions are for the sole purpose of getting to know you, they will not be considered in the acceptance process. Please be honest and sincere.

1. Do you live with both parents? Yes No

If the answer is **no**, please explain: _____

2. How you relate with the following persons?

	Very good	Good	regular	bad
father				
mother				
siblings				

3. If you could change something about your relationship with your parents, what would it be?

4. Father's Name: _____ Occupation: _____

Mother's Name: _____ Occupation: _____

MY RELATIONSHIP WITH GOD

Have you invited Christ to live in your heart? Yes No

How and when? _____

If you could change something about your relationship with God, what would be? _____

MEDICAL EXAM
To be filled out by the Doctor

_____ is applying for acceptance into
Applicants Name

Youth With A Mission, an organization with intense activities and hours that require good health. This evaluation would be taken into consideration for acceptance, due to the intensive activities. Conduct your evaluation on the following points:

	Normal	Abnormal	Explain
Head			
Ears			
Nose			
Throat			
Neck			
Thorax			
Cardiovascular			
Lungs			
Abdomen			
Genito-Urinary			
Muscle-skeletal			
Neurological			
Skin			

Do he/she suffer from any contagious diseases? _____

Are they taking Prescriptions? Which one? For what medical condition? _____

Are they able to walk 8-11 miles daily? [] Yes [] No

Doctor's Name _____ Lic.# _____

Doctor's signature and stamp _____

Doctor's address _____ Phone: _____

