|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name | First Name | | | | | Last Name | | | | Chinese Name | | | | | | | | | photo | | |
|  | | | | |  | | | |  | | | | | | | | |
| Gender | Male \_\_\_  Female \_\_\_ | | | Country of Birth | | | | | Date of Birth | | | | | | | | | |
| Address: | | | | | | | | | | | | | | | | | | |
| Public School: | | | | | | | | | | | | | | | | Grade | | |
| Chinese School: | | | | | | | | | | | | | | | | Grade | | |
| Nationality: | | | | | | | Cell Phone | | | | | | | | | | Student's Email | | | | |
|  | | | | | | | | | |  | | | | |
| T-Shirt Size:  \_\_S \_\_M \_\_L \_\_ XL  \_\_ XXL | | | | | | | Language Spoken At Home | | | | | | | | | | | Facebook Email Account | | | |
| \_\_Mandarin \_\_\_ English \_\_\_Others | | | | | | | | | | |  | | | |
| Parents Names | | First Name | | | Last Name | | | Chinese Name | | | | | | | Email | | | | | Nationality |
| Father | |  | | |  | | |  | | | | | | |  | | | | |  |
| Mother | |  | | |  | | |  | | | | | | |  | | | | |  |
| Home Phone | | | | | | | Father's Cell Phone | | | | | | | | | | | Mother's Cell Phone | | | |
|  | | | | | | |  | | | | | | | | | | |  | | | |
| Community Participation/Position/Years | | | | | | | | | | | | | Award/Place/Years | | | | | | | | |
|  | | | | | | | | | | | | |  | | | | | | | | |
| Health Information | | | | | | | | | | | | | | | | | | | | | |
| Have you ever had the following diseases?  Heart disease:  Asthma:  Kidney disease:  Liver disease:  Mental illness:  Epilepsy: | | | | | | | | | | | | Malaria:  Hypertension:  Diabetes:  Allergies:  Drug allergy: | | | | | | | | | |
| Health Insurance Information | | | | | | | | | | | | | | | | | | | | | |
| Card Holder Name:  Name of Insurance Company:  Expiration Date:  ID Number:  Insurance Plan: | | | | | | | | | | | | | | | | | | | | | |
| Emergency Contact | | | Phone | | | | | | | | Family Doctor's Name | | | | | | | | Family Doctor's Phone | | |
|  | | |  | | | | | | | |  | | | | | | | |  | | |
| Parent's Signature: | | | | | | | | | | | | | | Date: | | | | | | | |

備註：填寫完報名表後請連同保證金$100美元支票、營隊規則簽章表與醫療保險證明影本（支票抬頭：Culture Center of TECRO）郵寄至華府文教服務中心（Culture Center of TECRO, 901 Wind River Lane, Gaithersburg, MD 20878 Attn: Ms. Su）