



**Central Florida Dreamplex and Winds of Mercy
2016 Fall Membership Scholarship Application Form**
(Please Print Clearly)

Applicant Name: _____ Parent/Guardian: _____
Street: _____ City/St/Zip: _____
Applicant Date of Birth: _____ Age: _____ Gender: _____
Cell Phone: _____ Home/Work Phone: _____
Parent/Guardian Email: _____
Emergency Contact Name (other than a parent/guardian): _____
Emergency Home Number: _____ Emergency Cell Phone: _____
Participant's Primary Disability: _____
Is Participant a current Dreamplex Member? Y N

Scholarship Eligibility and Requirements

- 1) This scholarship covers an individual premium membership at the Central Florida Dreamplex for the period of August 1, 2016 through December 31, 2016.
- 2) Applications must be received no later than July 11, 2016. Scholarship recipients will be selected and notified by July 15, 2016.
- 3) Applicants must have a diagnosed disability. Ten scholarships are available to individuals ages six months through 21 years of age. Scholarships will be awarded first to those who can provide proof of financial need. (This may include, but is not limited to, proof of housing/food assistance, SSI, job loss or other hardship.)
- 4) Recipients must visit the Dreamplex at least two times each week to a) participate in a recreational therapy or fitness class or b) to exercise. Participants are allowed two approved excuses each month. If attendance requirements are not met, the scholarship will be transferred to another applicant.
- 5) By signing and submitting this form, applicants signify their agreement to these conditions. A separate release of liability and photography/video consent form will also be required when beginning the membership.

Parent/Guardian Signature

Date



WINDS OF MERCY REGISTRATION/ASSISTANCE APPLICATION		
WARRIOR INFORMATION		
Warrior Name:		
Date of birth:	Phone:	Sex: Male Female
Current address:		
City:	State:	ZIP Code:
School/Grade:	Hobbies:	Allergies:
PARENT INFORMATION		
Parent name:		
Email Address:		Phone:
Birthday:	Occupation:	
Spouse Name:	Email:	
Sibling Name/Age:	Sibling Name/Age:	Sibling Name/Age:
WARRIOR DIAGNOSIS AND SPECIAL NEED INFORMATION		
HOW DOES YOUR CHILD'S SPECIAL NEED AFFECT YOUR FAMILY'S LIFE?		

WHAT ASSISTANCE ARE YOU REQUESTING?

IS FINANCIAL HARDSHIP THE REASON WHY YOU ARE REQUESTING FINANCIAL ASSISTANCE IF SO, WHAT IS THE CAUSE OF THE FINANCIAL HARDSHIP? (SCHOLARSHIPS WILL BE AWARDED FIRST TO THOSE WHO CAN PROVIDE PROOF OF FINANCIAL NEED. THIS MAY INCLUDE BUT IS NOT LIMITED TO, PROOF OF HOUSING/FOOD ASSISTANCE, SSI, JOB LOSS OR OTHER HARDSHIP.)

HOW WILL THE ASSISTANCE IF PROVIDED, HELP YOUR CHILD AND YOUR FAMILY?

SIGNATURES

I hereby give my consent to Winds of Mercy to photograph, film, videotape and use, reproduce, and publish said images of me and or my children. I Agree the photographs/negatives, films, or video thereof shall constitute the sole property of Winds of Mercy with full right of disposition in any manner whatsoever, including the right to publish. I hereby release Winds of Mercy and his/her legal representatives and assigns from any and all claims whatsoever in connection with use, reproduction, publication of the images thereof.

Signature of applicant:

Date: