REGISTRATION CHECKLIST

Here is a checklist to ensure that you have all of the necessary paper in order to register your child. ALL OF THESE THINGS ARE NECESSARY IN ORDER TO REGISTER. NO EXCEPTION CAN BE MADE

Child’s Name: _________________________________

Parent/Guardian’s Name: __________________________________

_____ COMPLETED APPLICATION

_____ BOYS & GIRLS CLUB HEALTH FORM

_____ BIRTH CERTIFICATE

_____ JUNE 2018 REPORT CARD (PINK)

_____ $100.00 FOR REGISTRATION COVER FOR THE SCHOOL YEAR

_____ $25.00 FOR REGISTRATION FOR HIGH SCHOOL

PAYMENTS: Credit Card, Money Order, and or Bank Check (There is a $35 fee if your check cannot be processed)

Please make Checks & or Money Orders to

The Boys & Girls Club of Stamford

Date of Registration: ________________________ Staff initials: _________

Date info logged into computer: ________________________ Staff initials: _________
MEMBERSHIP APPLICATION
Boys & Girls Club of Stamford

First Name: ___________________________  Middle: ___________________________  Last: ___________________________

Nickname: ___________________________

Gender: ___ M ___ F  DOB: __________  SSN: _______________

Ethnicity:
___ White ___ Black/ African American ___ Asian ___ Black Hispanic ___ White Hispanic ___ Native American/Alaskan Native ___ Native Hawaiian/Pacific Islander ___ Multiracial
___ Other (Please specify): ____________________________

Address: ______________________________________________

City: ______________________   State: _________   Zip: ________________

Phone: ___________________   Email: ________________________________

School Information:
Current Teacher: ___________________________  Guidance Counselor: ___________________________
School: _________________________________________   Grade: __________

Medical Information:
Doctor Name: ______________________________________   Doctor Phone: ___________________________

Permission for Treatment by Doctor/Hospital: ___Yes ___No   Medicaid: ___Yes ___No

Does your family have health and/or accident insurance: ___Yes ___No
Insurance Carrier: ___________________________________________
Policy #: ___________________________   Group#: ___________________________________

Date Health Info Received ____________________

Serious Health Problems: ___Yes ___No   If Yes, explain: ___________________________________________

Medications: ___Yes ___No   If Yes, explain: ____________________________

Date Medical Info Received ____________________

General:
Birth Certificate on File: ___ Yes ___No   Birth City: __________   Birth State/Country: __________

Member/Contacts Understood Signed Insurance Disclaimer and Permission Statement: ___Yes ___No

Member has permission to be used in public relations materials: ___Yes ___No

Member may participate in all Club activates in or adjacent to the club building: ___Yes ___No

Club Member Since: __________   Religion: ________________
Household: *NOTE: This information is collected for Grant writing purposes ONLY. Our Scholarship and funding relies on this information. Please be very accurate in your responses.*

Member lives with ___Mom ___Step Mom ___Dad ___Step Dad ___Grandparent ___Other: __________

Housing Development: _______________________________________________________

<table>
<thead>
<tr>
<th>Gross</th>
<th>$0 - $5000</th>
<th>$5001 - $10,000</th>
<th>$10,001 - $15,000</th>
<th>$15,001 - $20,000</th>
<th>$20,001 - $25,000</th>
<th>$25,001 - $30,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Household Income:</td>
<td>$30,001 - $35,000</td>
<td>$35,001 - $40,000</td>
<td>$40,001 - $45,000</td>
<td>$45,001 - $50,000</td>
<td>$50,001 - $55,000</td>
<td>$55,001 - $60,000</td>
</tr>
<tr>
<td>$60,001 - $65,000</td>
<td>$65,001 - $70,000</td>
<td>$70,001 - $75,000</td>
<td>$75,001 - $80,000</td>
<td>$80,001 - $85,000</td>
<td>$85,001 - $90,000</td>
<td></td>
</tr>
</tbody>
</table>

Number in Household: _______________________

Is there a Member of the household 65 years old or older: ____Yes ____No

Is there a Member of the Household Handicapped: ____Yes ____No

Is there anyone who’s in the Military who lives in the Household: ____Yes ____No

Current Head of Household: ____Female ____Male

Current Single Parent: ____Yes ____No

Does Child receive Free or Reduced lunch: ____Yes ____No

Physical:

Eye Color: ________ Hair Color: ________ Skin Color/Features: ________

Height: __________ Weight: __________

T-Shirt Size:

Youth: ___S, ___M, _____ L Adult: ___S, ___M, _____ L, _____ XL

Walker’s Release:

I hereby give my permission to permit my child to walk home at the end of the program day. I fully approve of this dismissal procedure and by signing this release, I hereby release and hold harmless the Boys & Girls Club of Stamford of any and all responsibility with my child walking home.

Parent/Guardian Signature _____________________________________ Date _________________

Disclaimer:

I give my permission for my child ________________________________ to attend the summer camp program of the Boys & Girls Club and to participate in all activities. I understand that the program is not responsible for the personal property of participants. I authorize the Boys & Girls Club to use photographs of my child to the purpose of telling the program story and promoting the message of the program. In case of emergency, I understand every effort will be made to reach the parent or guardian or participants. In case I cannot be reached, I give permission to the physician selected by the Boys & Girls Club to hospitalize, secure proper treatment (order injections, anesthesia or surgery) for my child/ward as named above.

Parent/Guardian Signature _____________________________________ Date _________________
Membership and Parent Agreement:
As a member of the Boys & Girls Club of Stamford, I agree to bring my membership card every time I come in the Club and show it to the staff person at the front desk. I will bring it whether I'm coming to the Club for a game, class practice or open gym. I am aware that there will be a $5.00 charge to replace a lost card. I will treat all staff, members and parents with respect. I will care for all equipment as if it were my own. I understand that if I am, coughing swearing, stealing, fighting, disrespectful other members or staff, damaging equipment or property, lying or be involved in any action that the Club staff deems inappropriate, I can be removed from the Club for the day, evening, and depending on the seriousness of the offense, I may be suspended for a period of time. I have read the club handbook rule and regulations.

Member Signature: ____________________________________ Date: ________________________________
Parents Signature: _____________________________________ Date: ___________________________

Academic Release:
I, ____________________, have agreed to give the Program Coordinator permission to have access to my child’s academic records. The Programs Coordinator will have access throughout the entire school year for the purpose of monitoring my child’s academic progress. I give the Program Coordinator permission to meet with the guidance counselor or any school official regrading my child. The Program Coordinator will contact me prior to any such meeting to inform me of any need for such meeting. The Program Coordinator will submit to me in writing the results of all meetings held with my child’s guidance counselor or school officials.

Parent Signature: __________________________________________ Date: __________________________

I certify that the information is complete and correct to the best of my knowledge.

Parent/Guardian’s Name: ________________________________
Parent/Guardian’s Signature: __________________________________ Date: ________________

For Office Use Only:

Method of Payment:
Money Order: ________ Check: _________ (Payable to the Boys & Girls Club of Stamford) Credit card: ________
Membership #: ___________ Entry Date: __________ Expiration Date: __________ Status: __________ Type: ________ New/Renewal
Member: ___________ Processed by: ___________
MEMBERSHIP APPLICATION - CONTACTS
Boys & Girls Club of Stamford

Member’s Name: ______________________________

<table>
<thead>
<tr>
<th>PRIMARY CONTACT</th>
<th></th>
<th>PRIMARY CONTACT</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship to Member: ______________________</td>
<td></td>
<td>Relationship to Member: ______________________</td>
<td></td>
</tr>
<tr>
<td>Person Authorized to Pickup Member: ____</td>
<td></td>
<td>Person Authorized to Pickup Member: ____</td>
<td></td>
</tr>
<tr>
<td>Name: ______________________________________</td>
<td></td>
<td>Name: ______________________________________</td>
<td></td>
</tr>
<tr>
<td>DOB: ________________________________________</td>
<td></td>
<td>DOB: ________________________________________</td>
<td></td>
</tr>
<tr>
<td>Occupation: __________________________________</td>
<td></td>
<td>Occupation: __________________________________</td>
<td></td>
</tr>
<tr>
<td>Address W: _________________________________</td>
<td></td>
<td>Address W: _________________________________</td>
<td></td>
</tr>
<tr>
<td>Phone: ___________________ Type: ____________</td>
<td></td>
<td>Phone: ___________________ Type: ____________</td>
<td></td>
</tr>
<tr>
<td>Phone: ___________________ Type: ____________</td>
<td></td>
<td>Phone: ___________________ Type: ____________</td>
<td></td>
</tr>
<tr>
<td>Phone: ___________________ Type: ____________</td>
<td></td>
<td>Phone: ___________________ Type: ____________</td>
<td></td>
</tr>
<tr>
<td>Email: __________________</td>
<td></td>
<td>Email: __________________</td>
<td></td>
</tr>
</tbody>
</table>

Relationship to Member: ______________________
Parent/Guardian: ____ Emergency: ____
Person Authorized to Pickup Member: ____
Name: ______________________________________
DOB: ________________________________________
Occupation: __________________________________
Address W: _________________________________
Phone: ___________________ Type: ____________
Phone: ___________________ Type: ____________
Phone: ___________________ Type: ____________
Email: ______________________________________

Relationship to Member: ______________________
Parent/Guardian: ____ Emergency: ____
Person Authorized to Pickup Member: ____
Name: ______________________________________
DOB: ________________________________________
Occupation: __________________________________
Address W: _________________________________
Phone: ___________________ Type: ____________
Phone: ___________________ Type: ____________
Phone: ___________________ Type: ____________
Email: ______________________________________

Relationship to Member: ______________________
Parent/Guardian: ____ Emergency: ____
Person Authorized to Pickup Member: ____
Name: ______________________________________
DOB: ________________________________________
Occupation: __________________________________
Address W: _________________________________
Phone: ___________________ Type: ____________
Phone: ___________________ Type: ____________
Phone: ___________________ Type: ____________
Email: ______________________________________

Relationship to Member: ______________________
Parent/Guardian: ____ Emergency: ____
Person Authorized to Pickup Member: ____
Name: ______________________________________
DOB: ________________________________________
Occupation: __________________________________
Address W: _________________________________
Phone: ___________________ Type: ____________
Phone: ___________________ Type: ____________
Phone: ___________________ Type: ____________
Email: ______________________________________
YOUTH CAMP/ AFTERSCHOOL HEALTH EXAM/RECORD
FOR CAMPERS AND STAFF
Physical Exams Are Valid for 3 Years
From Date of Last Examination

Please Return Completed Form to the Boys & Girls Club of Stamford

☐ Campers
☐ Staff

Name: _________________________________ Date of Birth: ____/_____/______ Phone: __________________________
Guardian______________________________ Address_______________________________________
Emergency Contact________________________ Telephone____________________
Date of Arrival at Camp: ___________________ Departure Date: __________

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

Date of Exam ____/ ____/ _____

_____ May participate in all camp activities
_____ May Participate except for: ___________________________________________________________
_____________________________________________________________________________________

Medical information pertinent to routine care and emergencies: _________________________________
_____________________________________________________________________________________

Is this individual taking prescription or over the counter medication(s)?

☐ YES  If yes, please indicate medications: __________________________________________________

☐ NO

Does the individual have allergies?  YES ☐  NO ☐  If yes, Explain: ________________________________

Is the individual on a special diet?  YES ☐  NO ☐  If yes, Explain: ________________________________

Does the individual have special needs?YES ☐  NO ☐  If Yes, Explain: ______________________________

This Camper/Staff is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunizations Practices:

<table>
<thead>
<tr>
<th>Immunization</th>
<th>YES</th>
<th>NO</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diphtheria</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pertussis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chickenpox</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetanus</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments: __________________________________________________________________________________

___________________________________________________________________________________________

Print name of medical care provider: ____________________________________________________________________________

Medical care provider’s address: ________________________________________________________________________________

Medical care provider’s: City/Town_____________ ST _______ Zip Code________

Signature of Physician, APRN or PA ______________________________________________________________________________

Date Form Signed ________/_____/_______

Telephone Number: (_____) _______ - _______