

CLUB CARE



BOYS & GIRLS CLUBS
OF BENTON AND FRANKLIN COUNTIES

Membership Application

Member Information

First Name: _____ Middle: _____ Last Name: _____ Gender: Male / Female

Race: American Indian/Alaskan Native Asian & White Black White Asian
 Native Hawaiian/Other Pacific Islander American Indian/Alaskan Native & Black/African American
 American Indian/Alaskan Native & White Black/African American & White Other Multi-racial: _____

Ethnicity: (MUST CHOOSE ONE) **Hispanic** **Not Hispanic** Date of Birth: ___ / ___ / ___ Age: _____

School: _____ Home Phone: _____ Grade: _____

Parent Information

*Please complete each line, if the information is the same write same, please write none if no information is available

Mothers Name: _____

Fathers Name: _____

Address: _____

Address: _____

City: _____ Zip Code: _____

City: _____ Zip Code: _____

Employer: _____

Employer: _____

Work Phone: _____

Work Phone: _____

Cell Phone/Pager: _____

Cell Phone/Pager: _____

Email Address: _____

Email Address: _____

Emergency Contact Information

*Please use separate contacts to allow for easy access in the event of an emergency

Emergency Contact #1: _____ Phone: _____ Relationship to Child: _____

Emergency Contact #2: _____ Phone: _____ Relationship to Child: _____

Authorized to Pick-Up: _____
(Emergency Contacts are assumed to be authorized to pick up a child. Only authorized adults with a valid ID will be allowed to pick-up children from a location.)

Not Authorized To Pick-Up by court order (court order must be attached): _____

Medical Information

Doctor: _____ Phone: _____ Dentist: _____ Phone: _____

Doctor Address: _____ Dentist Address: _____

Date of Last Doctor Visit: ___ / ___ / ___ Reason for Visit: _____

Insurance Carrier: _____ Policy#: _____ Group#: _____

Serious Health Problems: _____ Allergies: _____ Medications: _____

Statistical Information

*This information is only used to build demographics for grant purposes and is kept strictly confidential

Child Lives With: Both Parents Mother Father Step Mom Step Dad Grandparent Foster Parent Other

___ # In Family ___ # Of Brothers ___ # Of Sisters ___ # In Household over age of 65 ___ Member of Household Handicapped

How did you hear about the Boys & Girls Clubs of Benton and Franklin Counties? _____

Total Household Income Information (Please Check One):

\$5,000-18,500 \$18,501-24,750 \$24,751-30,950 \$30,951-35,900 \$35,901-39,600 \$39,601-44,550 \$44,551-49,500

\$49,501-53,500 \$53,501-57,450 \$57,451-61,400 \$61,401-65,350 \$65,351-71,800 \$71,801-81,700 \$81,701+

Permission and Release

Parent Handbook and Fees

I agree to abide by the terms and conditions of the Boys & Girls Club Parent Handbook (a copy of which I have received and/or will be made available to me upon request) governing the enrollment of the child on this Membership Application/Emergency Form.

Field Trip Transportation

I agree to permit the child named to participate in walking trips, field trips or other activities sponsored by the Boys & Girls Club. This permission is given with the understanding that transportation, if needed, will be provided by the Boys & Girls Club by Club Vehicle driven by Boys & Girls Club staff members or school buses and/or public transportation. I agree to provide a booster seat for my child if they are 8 years of age or younger, or shorter than 4'10".

Supervision of Field Trips

I also understand that the children will be under Club Staff supervision throughout the duration of any field trip.

Safety

Knowing there is a certain amount of risk involved in even the simplest of children's games, sports and activities, I give permission for my child to participate in Club activities and programs. I accept responsibility in the unlikely event that an accident might take place. I hereby certify that I carry Health and/or Accident Insurance for my child and that I am solely responsible for the cost for health care for my child; even as a result of my child's participation in Club programs or activities.

Insurance Coverage

I further certify that my child is covered by medical insurance as listed on the above Membership/Emergency Form. I understand that I am solely responsible to provide such coverage. I understand that I am solely responsible for any consequences of my failure to provide adequate insurance coverage. I agree to abide by all the rules of the Boys & Girls Clubs of Benton and Franklin Counties pertaining to the health and safety of the members and to inform the Club immediately of any change in my child's health, health care insurance, or medical provider. I also agree to inform the Boys & Girls Clubs of Benton and Franklin Counties immediately if my child contacts a serious communicable disease.

Negligence

I agree that the Boys & Girls Clubs of Benton and Franklin Counties, its employees (both paid and volunteer), Board of Directors and affiliated agencies, shall not be liable for any claims, demands, injuries, damages, actions or causes of action, whatsoever for any injury caused to me or to my child as a result of my child's involvement in Boys & Girls Club programs or activities.

I hereby expressly forever relieve and discharge said Boys & Girls Clubs of Benton & Franklin Counties from all acts of negligence on the part of the Boys & Girls Clubs of Benton and Franklin Counties, its employees (both paid and volunteer), the corporation, its servants, agents, officers, shareholders, and affiliated agencies.

Fee Payment Policy

I understand that payment of program fees is made on a session by session basis and that prepayment is required. I agree to abide by the terms and conditions of the Boys & Girls Club Fee Policies. A \$10 late fee will be added to my account if payment is not received by Wednesday of each week. A \$25 processing fee will be assessed for any requested reimbursement of balance on your account. NSF Checks will be assessed a \$25 fee for each occurrence.

Authorization and Agreement

In case of serious accident or illness to my child or in the event that the injury/illness involves my child's mouth or teeth, I hereby authorize the staff of the Boys & Girls Clubs of Benton and Franklin Counties, my children's physician, dentist, emergency personnel, and those individuals named on the Membership Form to give any necessary treatment to my child, including emergency surgery. You may call the doctor and/or ambulance if necessary at my exclusive expense. I agree that I am solely responsible for updating medical information to the Boys & Girls Clubs of Benton and Franklin Counties.

I understand the implication of this Permission and Statement of Release. I certify that I am legally capable of executing this agreement, and that I have so of my own free will on the date indicated below, on behalf of myself, my spouse, if not signed separately, and our child for whom this form was prepared. *I further certify that all information provided is the most current and understand that it is my duty to update this information should anything including but not limited to: change of address; change of school; change of employment; change of number in household; change of income; change of medical information occur. This information may be verified by the local or Federal government.*

I understand that my signature below indicates my understanding of the above statements and gives my permission for my child to attend field trips as well as my understanding of fees and authorizations.

Signature of Parent/Legal Guardian _____ Date _____

Signature of Second Parent/Legal Guardian _____ Date _____ (optional)

Photo Consent

Yes, I give permission for the Boys & Girls Clubs organization to use photographs and other types of visual media including but not limited to video footage of my child for promotional purposes, and to waive any claims I may have against the Boys & Girls Clubs for all thereof.

No, I do not give permission for the Boys & Girls Clubs to use images of my child.



Reviewed by: _____ Date: _____

Staff Signature

Is there an accompanying signed Certificate of Exemption on file? Yes No

Certificate of Immunization Status (CIS)

Child's Last Name: _____ First Name: _____ Middle Initial: _____ Child's Address: _____

Child's Birthdate: _____ Child's Sex: _____

Parent/Guardian Name: _____ Parent/Guardian Day Phone: _____

If completing by hand, write the vaccine in the row to the left of "Dose" and the date the vaccine was received in the "Date" column. Age column is optional.
 • Required for School and Child Care/Preschool • Required for Child Care/Preschool Only

Vaccine	Dose	Date	Age	Vaccine	Dose	Date	Age
◆ Hepatitis B (Hep B)							
	1			● Pneumococcal (PCV, PPV)	1		
	2				2		
	3				3		
					4		
Hepatitis B (Hep B) Alternate schedule for teens							
	1			◆ Polio (IPV, OPV)			
	2				1		
Rotavirus							
	1				2		
	2				3		
	3				4		
◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)							
	1						
	2						
	3						
	4						
	5						
◆ Diphtheria, Tetanus, Pertussis (Tdap, Td)							
	1						
	2						
● Haemophilus influenzae type b (Hib)							
	1						
	2						
	3						
	4						

◆ Measles, Mumps, Rubella (MMR)

1 _____ 2 _____

◆ Varicella (chickenpox)

1 _____ 2 _____

◆ Other

I certify that the information provided here is correct and verifiable.

Signature of Parent or Guardian _____ Date _____

Licensed HCP Signature (MD, DO, ND, PA, ARNP) _____ Date _____

Either initial with parent approval or get parent signature below:
 Staff initials indicating parent approval: _____
 Parent Signature indicating approval: _____

Verification of varicella disease history

Health Care Provider (HCP) Verified Signed note from HCP attached or HCP provider signature here: _____

HCP Verified by Registry No HCP Sig required if box at left checked. **If school staff find verification in the Registry, then school staff must:** _____

Parental Report ONLY acceptable for some grades. Write date or age child had disease: _____

See the back of this page for documentation of immunity, a vaccine trade name reference guide, and a vaccine abbreviation list.

Certificate of Exemption (COE)

From School, Child Care and Preschool Immunization Requirements¹



Washington State Department of Health

DOH 348-106 Revised: 10/15/08

Child's Last Name:	First Name:	Middle Initial:	Child's Address:
Child's Birthdate:	Child's Sex:		Parent/Guardian Day Phone:
Parent/Guardian Name:			

Please choose the exemption(s) that apply to your child as listed below.

Temporary Medical Exemption

Permanent Medical Exemption

I certify that the child named on this form is medically exempted from the requirement for the following vaccine(s):

Vaccine(s)	Until	Date (or Perm.)
X		
Type or Print Name of Licensed Health Care Provider (MD, DO, ND, PA, ARNP)		
X		
Signature of Licensed Health Care Provider		Date

Personal/Philosophical Exemption

Religious Exemption

I do not want my child to get the following vaccine(s).

- | | | |
|--|---|---|
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Hib |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Mumps | <input type="checkbox"/> Pertussis (whooping cough) |
| <input type="checkbox"/> Pneumococcal | <input type="checkbox"/> Polio | <input type="checkbox"/> Rubella |
| <input type="checkbox"/> Tetanus | <input type="checkbox"/> Varicella (chickenpox) | |
| <input type="checkbox"/> Other (indicate): | | |

Parent/Guardian Notice: "I certify that the information provided here is correct and verifiable. I understand that if there is an outbreak of a vaccine-preventable disease my child has not been fully immunized against (as indicated above, for medical, personal/philosophical or religious reasons), my child may be at risk for disease and can be **excluded** from school, child care or preschool until the outbreak is over."

Signature of Parent/Guardian

Date

¹ RCW 28A.210.080-090 state that before or on the first day of every child's attendance at any public and private school or licensed day care center in Washington State must present proof of either: (1) full immunization, (2) the initiation of and compliance with a schedule of immunization, as required by rules of the state board of health, or (3) a certificate of exemption, signed by a parent or guardian. Medical exemptions must be signed by a licensed health care provider.