

CLUB CARE



BOYS & GIRLS CLUBS
OF BENTON AND FRANKLIN COUNTIES

START DATE _____ END DATE _____

ENROLLMENT YEAR

Member Information

First Name: _____ Middle: _____ Last Name: _____ Gender: Male / Female
Date of Birth: ___ / ___ / _____ Age: _____ School _____ Grade: _____

Race
(circle one): American Indian/Alaskan Native African American Asian Caucasian
Hispanic Native Hawaiian/Other Pacific Islander Other: _____

Parent/Guardian 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: _____

Member lives with (Circle One): Both Parents Mother ONLY Father ONLY Parent & Step Parent Other
In Family _____ # of Brothers _____ # of Sisters _____ # In Household over age 65 : _____

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

Emergency Contact #1: _____ Address: _____
Phone: _____ Relationship to Child: _____
Emergency Contact #2: _____ Address: _____
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

Does this child receive free or reduced lunch at school? Yes No Have parents/guardians ever served in the military? Yes No

How did you hear about the Boys & Girls Club? _____

Total household income	_____ \$15,601 - \$17,550	_____ \$24,201 - \$26,000	_____ \$37,701 - \$41,600	_____ \$64,501 - \$68,650
(please circle one):	_____ \$17,551 - \$19,500	_____ \$26,001 - \$29,250	_____ \$41,601 - \$46,800	_____ \$65,651 - \$85,800
	_____ \$19,501 - \$21,100	_____ \$29,251 - \$32,500	_____ \$46,801 - \$52,000	_____ \$85,801+
	_____ \$21,101 - \$22,650	_____ \$32,501 - \$35,100	_____ \$56,201 - \$60,350	
	_____ \$22,651 - \$24,200	_____ \$35,101 - \$37,700	_____ \$60,351 - \$64,500	

PERMISSION & RELEASE

PLEASE INITIAL NEXT TO EACH LINE
ITEM VERIFYING YOUR UNDERSTANDING

Parent Handbook/Policies and Procedures Manual

_____ 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. Also made available upon request, is the Policies and Procedures Manual including the Health Care Plan, Pesticide Policy, Safety Management Plan and Disaster Plan.

Field Trip Transportation

_____ I agree to permit my child 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, school buses or public transportation. When it is requested, 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 my child will be under staff supervision throughout the duration of any field trip. One staff member for every 10 children will be present.

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.

Report Cards

_____ As part of our reporting to Boys & Girls Clubs of America, we are asking your permission to copy your child's report card and track their grades throughout the school year. We will keep this information confidential and when we do our reporting to our National Headquarters we only use statistics and general numbers.

Insurance Coverage

_____ I further certify that my child is covered by medical insurance as listed on the above Membership Application. 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 contracts 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 the Boys & Girls Clubs of Benton and 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 agree to abide by the terms and conditions of the Boys & Girls Club Fee Policies. A \$10 fee may be assessed if payment for care is made late. A \$25 processing fee will be assessed for any requested reimbursement of balance on your account. NSF Checks will be assessed a \$40 fee for each occurrence.

Emergency Medical Treatment

_____ 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 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 change.

My signature below indicates my understanding of the above terms and conditions of my child's enrollment at the Boys & Girls Clubs of Benton and Franklin Counties.

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 of Benton and Franklin Counties to use photographs and other types of visual media 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 of Benton and Franklin Counties to use photographs or other types



Certificate of Immunization Status (CIS)

DOH 348-013 January 2010

Office Use Only:	
Reviewed by: _____	Date: _____
Signed Cert. of Exemption on file? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Please print. See back for instructions on how to fill out this form or get it printed from the Immunization Registry.

Child's Last Name: _____	First Name: _____	Middle Initial: _____	Birthdate (mm/dd/yyyy): _____	Sex: _____	I certify that the information provided on this form is correct and verifiable.
Symbols below: ◆ Required for School and Child Care/Preschool ● Required for Child Care/Preschool Only				Parent/Guardian Name (please print): _____	

Vaccine	Dose	Date		
		Month	Day	Year
◆ Hepatitis B (Hep B)				
	1			
	2			
	3			
or Hep B - 2 dose alternate schedule for teens				
	1			
	2			
Rotavirus (RV1, RV5)				
	1			
	2			
	3			
◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)				
	1			
	2			
	3			
	4			
	5			
◆ Tetanus, Diphtheria, Pertussis (Tdap, Td)				
	1			
	2			
● Haemophilus influenzae type b (Hib)				
	1			
	2			
	3			
	4			
● Pneumococcal (PCV, PPSV)				
	1			
	2			
	3			
	4			

Vaccine	Dose	Date		
		Month	Day	Year
◆ Polio (IPV, OPV)				
	1			
	2			
	3			
	4			
Influenza (flu, most recent)				
◆ Measles, Mumps, Rubella (MMR)				
	1			
	2			
◆ Varicella (chickenpox) or verify disease 1-4 ▶				
	1			
	2			
Hepatitis A (Hep A)				
	1			
	2			
Meningococcal (MCV, MPSV)				
	1			
Human Papillomavirus (HPV)				
	1			
	2			
	3			
Office Use Only: Immunization information updated and verified with parent/guardian permission:				
Printed Staff Name	Date	Printed Staff Name	Date	
Printed Staff Name	Date	Printed Staff Name	Date	

If the child named on this CIS had chickenpox disease (and not the vaccine), disease history must be verified. **Mark option 1, 2, 3, OR 4 below – see, back #5.**

1) Chickenpox disease verified by printout from CHILD Profile Immunization Registry
Must be marked by printout (not by hand) to be valid.

2) Chickenpox disease verified by Health Care Provider (HCP)
If you choose this box, mark 2A OR 2B below.
 2A) Signed note from HCP attached OR
 2B) HCP signed here and print name below:

 Licensed health care provider (HCP) Signature _____ Date _____
 (MD, DO, ND, PA, ARNP)
 HCP Printed Name: _____

3) Chickenpox disease verified by school staff from CHILD Profile Immunization Registry
If you choose this box, staff must initial that parent or guardian approves: _____ (initial) _____ (date)

4) Chickenpox disease verified by parent*
If you choose this box, fill in the date or child's age when he or she had the disease:
 Age/Date of disease: _____
 *Can ONLY verify for some grades, see back #5 (4).

If the child can show immunity by blood test (titer) and hasn't had the vaccine, ask your HCP to fill in this box.
Documentation of Disease Immunity

I certify that the child named on this CIS has laboratory evidence of immunity (titer) to the diseases marked. **Signed lab report(s) MUST also be attached.**

<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Mumps	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Polio	
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Rubella	
<input type="checkbox"/> Hib	<input type="checkbox"/> Tetanus	
<input type="checkbox"/> Measles	<input type="checkbox"/> Varicella	

Licensed health care provider (HCP) Signature _____ Date _____
 (MD, DO, ND, PA, ARNP)
 HCP Printed Name: _____

Instructions for completing the Certificate of Immunization Status (CIS): printing it from the Immunization Registry or filling it in by hand.

#1 To print with info filled in: First, ask if your health care provider's office puts vaccination history into the CHILD Profile Immunization Registry (Washington's statewide database). If they do, ask them to print the CIS from CHILD Profile and your child's information will fill in automatically. **Be sure** to review all the information, **sign and date the CIS** in the upper right hand box, and return it to school or child care. If your provider's office does not use CHILD Profile, ask for a copy of your child's vaccine record so you can fill it in by hand using steps #2-7 (below):

EXAMPLE

#2 To fill in by hand: Print your child's name, birthdate, sex, and your own name in the top box.

#3 Write each vaccine your child received under the correct disease. Write the vaccine type under the "Vaccine" column and the date each dose was received in the "Month," "Day," and "Year" columns (as mm/dd/yyyy). For example, if DTaP was received Jan 12, March 20, June 1, '11, fill in as shown here ▶

Vaccine	Dose	Date		
		Month	Day	Year
◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)				
DTaP	1	01	12	2011
DTaP	2	03	20	2011
DTaP	3	06	01	2011

#4 If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guide below to record each vaccine correctly. For example, record Pediarix under Diphtheria, Tetanus, Pertussis as **DTaP**, Hepatitis B as **Hep B**, and Polio as **IPV**.

#5 If your child has had chickenpox (varicella) disease and not the vaccine, **use only one** of these four options to record this on the CIS:

- 1) If your child's CIS is printed directly from the CHILD Profile Immunization Registry (by your health care provider or school system), and disease verification is found, box 1 is automatically marked. To be valid, this box must be marked by the Immunization Registry printout (not by hand).
- 2) If your health care provider (HCP) can verify that your child has had chickenpox, mark box 2. Then mark either 2A to attach a signed note from your HCP, or 2B if your HCP signs and dates in the space provided. Be sure your HCP's full name is also printed.
- 3) If school staff access the CHILD Profile Immunization Registry and see verification that your child has had chickenpox, they will mark box 3. Then, they must initial and date that they got parent or guardian approval to mark this box (i.e. make this change) to the CIS.
- 4) If your child started kindergarten in the 2008-2009 school year or later, you **CANNOT** use this box. If your child started kindergarten before the 08-09 school year, mark this box if you know he or she has had chickenpox. If you mark box 4, you must also write the approximate age or date your child had chickenpox. To find out which grades require chickenpox vaccine (or history), visit: <http://www.doh.wa.gov/cfh/immunize/schools/vaccine.htm>

#6 Documentation of Disease Immunity: If your child can show immunity by blood test (titer) and has not had the vaccine, have your health care provider (HCP) fill in this box. Ask your HCP to mark the disease(s), sign, date, print his or her name in the space provided, and **attach signed lab reports**.

#7 Be sure to **sign and date the CIS** in the upper right hand box, and return to school or child care.

#8 If a school or child care makes a change to your CIS, staff will print their name in the middle bottom box and date to show that you gave approval.

Vaccine Trade Names in alphabetical order									
ActHIB	Hib	Engerix-B	Hep B	Ipol	IPV	Pentavalente	DTaP + Hep B + Hib	TriHIBit	DTaP + Hib
Adacel	Tdap	Fluarix	Flu (TIV)	Infanrix	DTaP	Pneumovax	PPSV or PPV23	Tripedia	DTaP
Afluria	Flu (TIV)	FluLaval	Flu (TIV)	Kinrix (Knrx)	DTaP + IPV	Prevnar	PCV or PCV7 or PCV13	Twinrix (Twnrx)	Hep A + Hep B
Boostrix	Tdap	FluMist	Flu (LAIV)	Menaetra	MCV or MCV4	ProQuad (PrQd)	MMR + Varicella	Vaqa	Hep A
Cervarix	HPV2	Fluvirin	Flu (TIV)	Menomune	MPSV or MPSV4	Quadracel (Qdrel)	DTaP + IPV	Varivax	Varicella
Comvax (Cmvx)	Hep B + Hib	Fluzone	Flu (TIV)	Pediarix (Pdrx)	DTaP + Hep B + IPV	Recombivax HB	Hep B		
Daptacel	DTaP	Gardasil	HPV4	PedvaxHIB	Hib	Rotarix	Rotavirus (RV1)		
Decavac	Td	Havrix	Hep A	Pentacel (Pntcl)	DTaP + Hib + IPV	RotaTeq	Rotavirus (RV5)		

Vaccine Abbreviations in alphabetical order							
DT	Diphtheria, Tetanus	Hep A (HAV)	Hepatitis A	MPSV or MPSV4	Meningococcal Polysaccharide Vaccine	Rota (RV1 or RV5)	Rotavirus
DTaP	Diphtheria, Tetanus, acellular Pertussis	Hep B (HBV)	Hepatitis B	MMR / MMRV	Measles, Mumps, Rubella / with Varicella	Td	Tetanus, Diphtheria
DTP	Diphtheria, Tetanus, Pertussis	Hib	<i>Haemophilus influenzae</i> type b	OPV	Oral Poliovirus Vaccine	Tdap	Tetanus, Diphtheria, acellular Pertussis
Flu (TIV or LAIV)	Influenza	HPV	Human Papillomavirus	PCV or PCV7 or PCV13	Pneumococcal Conjugate Vaccine	TIG	Tetanus immune globulin
HBIG	Hepatitis B Immune Globulin	IPV	Inactivated Poliovirus Vaccine	PPSV or PPV23	Pneumococcal Polysaccharide Vaccine	VAR or VZV	Varicella

2010-05-10

Certificate of Exemption

For School, Child Care and Preschool Immunization Requirements¹



DIRECTIONS: All exemptions must have a licensed health care provider sign & date Box 1 ('Provider Statement').² Exception: Box 1 is not required for religious exemptions when Box 2 ('Demonstration of Religious Membership') is completed. All exemptions must also have a parent/guardian sign & date Box 3 ('Parent/Guardian Statement').

Child's Last Name:	First Name:	Middle Initial:	Birthdate (mm/dd/yyyy):	Sex:	Parent/Guardian Name (please print):
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Parent/Guardian, please choose the exemption(s) that apply to your child below.

<input type="checkbox"/> Temporary Medical Exemption <input type="checkbox"/> Permanent Medical Exemption <hr/> Vaccine(s) _____ Until _____ Date (or Permanent) <hr/> Print Name of Licensed Health Care Provider (MD, DO, ND, PA, ARNP) <hr/> X _____ X _____ Signature of Licensed Health Care Provider Date	<input type="checkbox"/> Personal/Philosophical Exemption (see Box 1) <input type="checkbox"/> Religious Exemption (see Box 1) <input type="checkbox"/> Religious Membership Exemption (see Box 2) 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): _____
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Box 1
<p>Provider Statement²: "I, _____, am a qualified provider (MD, DO, ND, PA, ARNP) licensed under Title 18 RCW. I confirm that the parent or guardian signing in Box 3 (Parent/Guardian Statement) has received information on the benefits and risks of immunization to their child as a condition for exempting their child for medical, religious, personal, or philosophical reasons." X _____ Signature of Licensed Health Care Provider (MD, DO, ND, PA, ARNP) X _____ Date</p>

Box 2
<p>Parent/Guardian Demonstration of Religious Membership: "I am a member of a church or religious body whose beliefs or teachings do not allow for medical treatment from a health care practitioner. By supplying the information requested below, no further proof or signed provider statement in Box 1 is required for this religious exemption." X _____ Name of Church or Religious Body X _____ X _____ Signature of Parent or Guardian Date</p>

Box 3
<p>Parent/Guardian Statement: "I certify that all the information provided on this certificate 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." X _____ X _____ Signature of Parent or Guardian Date</p>

If you have a disability and need this document in a different format, please call 1-800-525-0127 (TDD/TTY 1-800-833-6388).

¹ RCW 28A.210.080-090 states that before or on the first day of every child's attendance at any public and private school or licensed child care center in Washington State, the parent or guardian 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 and a licensed health care provider.

² A letter may substitute for a signed 'Provider Statement' on this certificate. To be accepted, the letter must reference the child's name on this certificate, confirm that the child's parent or guardian got information on the risks and benefits of immunization to their child, and be signed by a licensed health care provider.

**Authorization for Medical Treatment/
Emergency Treatment**

In case of serious accident or illness to my child's body or in the event that the injury/illness involves my child's mouth or teeth, I hereby authorized the staff of the Boys & Girls Clubs of Benton and Franklin Counties, my child'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 for updating medical information to the Boys & Girls Clubs of Benton and Franklin Counties.

Permission for Field Trips

I give permission for my child to attend the field trips provided by the Boys & Girls Club. I give Boys & Girls Club Staff permission to provide transportation by Ben Franklin Transit or Club van. I know that my child may walk to field trips. I understand that the Boys & Girls Club is not liable for any injuries, which may be incurred while being transported or while walking.

Signature of Parent/Legal Guardian _____

Date _____ **Cell phone** _____

Emergency Information Card

Child's Name _____ D.O.B. _____

Father's Name _____ Home# _____

Work Place _____ Work # _____

Mother's Name _____ Home # _____

Work Place _____ Work # _____

Please list 2 emergency contacts in case we are unable to contact you in the event of an accident/illness that requires we send your child home.

Name _____ # _____

Name _____ # _____

Medications _____