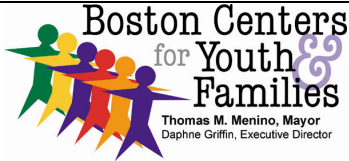


For Office Use Only

Site: _____ Date Received: _____

Staff Member Entering: _____ ID: _____ Fee Type: _____



Family/Adult Only Membership Application

The mission of Boston Centers for Youth & Families is to enhance the quality of life for Boston residents by partnering with community center councils, agencies, and businesses to support children, youth, individuals and families through a wide range of comprehensive programs and services according to neighborhood needs.

HEAD OF HOUSEHOLD INFORMATION (Parent/Guardian) – Member 1

First Name: _____ Last Name: _____ Female Male

Home Address: _____
Street Apt. City/Neighborhood Zip Code

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Date of Birth: _____

Ethnicity (select all that apply): Asian Black Native American Native Hawaiian White
 Are you of Hispanic or Latino origin? Yes No

To better serve the needs of our families and connect them to City services, we are requesting the following information.

Annual Household Income: Below \$10,830 \$10,831-14,570 \$14,571-18,310 \$18,311-22,050 \$22,051-25,790
 \$25,791-29,530 \$29,531-33,270 \$33,271-37,010 \$37,011-49,999 \$50,000-74,999 \$75,000+

Number of Family Members: _____

Housing: Rent Own Public Housing/Section 8 Shelter Other: _____

Assistance Programs (select all that apply): Day Care Voucher SNAP/Food Stamps General Assistance
 Temporary Assistance for Needy Families (TANF) Medicaid SSDI SSI Veterans Compensation

Medical Information

Health Insurance Company: _____

Physician Name: _____ Physician Phone Number: _____

Do you have any medical conditions or allergies? No Yes. If yes, please select type/s and describe below:

Allergies Asthma Physical Restrictions Medications Other: _____

Description: _____

Is there any additional information we should know about this you? No Yes

If yes, please list: _____

Emergency Contact Information

Please specify two people (**other than a parent or guardian for youth**) who can be contacted in case of emergency.
 (These two contacts are authorized to pick-up youth family members from the Boston Centers for Youth & Families Community Center.)

Primary Contact Name: _____ Relationship to member: _____

Home Address: _____
Street Apt. City/Neighborhood Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Secondary Contact Name: _____ Relationship to member: _____

Home Address: _____
Street Apt. City/Neighborhood Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

SPOUSE/PARTNER/SECOND PARENT/GUARDIAN INFORMATION – MEMBER 2

First Name: _____ Last Name: _____ Female Male

Home Address: Check here if same as Head of Household or

_____ Street Apt. City/Neighborhood Zip Code

Home Phone: Check here if same as Head of Household or _____

Cell Phone: _____ Work Phone: _____

Email: _____ Date of Birth: _____

Ethnicity (select all that apply): Asian Black Native American Native Hawaiian White
Are you of Hispanic or Latino origin? Yes No

Medical Information

Health Insurance Company: _____

Physician Name: _____ Physician Phone Number: _____

Do you have any medical conditions or allergies? No Yes. If yes, please select type/s and describe below:

Allergies Asthma Physical Restrictions Medications Other: _____

Description: _____

Is there any additional information we should know about this member? No Yes

If yes, please list: _____

The application is factual and complete to the best of my ability.

I hereby waive and release any and all rights, causes of action, and claims for damages I may have against the City of Boston, Boston Centers for Youth & Families, and any and all other associated individuals or organizations, for any and all personal injuries or property damage resulting from my participation in Boston Centers for Youth and Families Programs.

I, the undersigned parent or guardian of [_____], a minor, hereby consent to his/her Boston Centers for Youth and Families membership and waive and release any and all rights, causes of action and claims for damages I may have against the City of Boston, Boston Centers for Youth & Families, and any and all other associated individuals or organizations, arising out of any and all personal injuries or property damage which I may now or hereafter have as the parent or guardian of said minor, and also all rights, causes of action, and claims which said minor has or may acquire resulting from his/her participation in the program.

I give consent for me/my child to be administered first aid and to be treated by an emergency medical technician-paramedic, nurse or physician. Any follow up medical attention may be given at a local hospital and transportation to a Boston hospital is authorized. I give my consent for photographs, audiotapes, and video records of me/my child to be used by Boston Centers for Youth & Families for publicity purposes. I also agree to allow Boston Centers for Youth & Families to use photographs, audiotapes, video records or other work produced by the member for publicity purposes.

I understand that transportation is not provided and it is my responsibility to arrange transportation to and from Boston Centers for Youth & Families Community Centers.

Failure to comply with these rules and expectations can lead to termination of membership.

Signature of Member Date

Signature of Member Date

For Office Use Only

Site: _____ Date Received: _____

Staff Member Entering: _____ ID: _____ Fee Type: _____

MEMBER 3 (CHILD)

First Name: _____ Last Name: _____

Birth Date: _____ Gender: Female Male

Ethnicity (select all that apply): Asian Black Native American Native Hawaiian White
Are you of Hispanic or Latino origin? Yes No

School: _____ Grade: _____
Type of School: Public Charter Private/Parochial Homeschool

Child lives with (select all that apply): Both Parents Mother Only Father Only Aunt/Uncle
 Sister/Brother Step Parent Grandparent Foster Parent Guardian Other: _____

Home Address: Check here if same as Head of Household or _____

Home Phone: Check here if same as Head of Household or _____

Cell Phone: _____ Work Phone: _____ Email: _____

Medical Information

Health Insurance Company: _____

Physician Name: _____ Physician Phone Number: _____

Do you have any medical conditions or allergies? No Yes. If yes, please select type/s and describe below:
 Allergies Asthma Physical Restrictions Medications Other: _____

Description: _____

Is there any additional information we should know about this member? No Yes
If yes, please list: _____

MEMBER 4 (CHILD)

First Name: _____ Last Name: _____

Birth Date: _____ Gender: Female Male

Ethnicity (select all that apply): Asian Black Native American Native Hawaiian White
Are you of Hispanic or Latino origin? Yes No

School: _____ Grade: _____
Type of School: Public Charter Private/Parochial Homeschool

Child lives with (select all that apply): Both Parents Mother Only Father Only Aunt/Uncle
 Sister/Brother Step Parent Grandparent Foster Parent Guardian Other: _____

Home Address: Check here if same as Head of Household or _____

Home Phone: Check here if same as Head of Household or _____

Cell Phone: _____ Work Phone: _____ Email: _____

Medical Information

Health Insurance Company: _____

Physician Name: _____ Physician Phone Number: _____

Do you have any medical conditions or allergies? No Yes. If yes, please select type/s and describe below:
 Allergies Asthma Physical Restrictions Medications Other: _____

Description: _____

Is there any additional information we should know about this member? No Yes
If yes, please list: _____

MEMBER 5 (CHILD)

First Name: _____ Last Name: _____

Birth Date: _____ Gender: Female Male

Ethnicity (select all that apply): Asian Black Native American Native Hawaiian White
Are you of Hispanic or Latino origin? Yes No

School: _____ Grade: _____
Type of School: Public Charter Private/Parochial Homeschool

Child lives with (select all that apply): Both Parents Mother Only Father Only Aunt/Uncle
 Sister/Brother Step Parent Grandparent Foster Parent Guardian Other: _____

Home Address: Check here if same as Head of Household or _____

Home Phone: Check here if same as Head of Household or _____

Cell Phone: _____ Work Phone: _____ Email: _____

Medical Information

Health Insurance Company: _____

Physician Name: _____ Physician Phone Number: _____

Do you have any medical conditions or allergies? No Yes. If yes, please select type/s and describe below:
 Allergies Asthma Physical Restrictions Medications Other: _____

Description: _____

Is there any additional information we should know about this member? No Yes

If yes, please list: _____

The application is factual and complete to the best of my ability.

I hereby waive and release any and all rights, causes of action, and claims for damages I may have against the City of Boston, Boston Centers for Youth & Families, and any and all other associated individuals or organizations, for any and all personal injuries or property damage resulting from my participation in Boston Centers for Youth and Families Programs.

I, the undersigned parent or guardian of [_____] , a minor, hereby consent to his/her Boston Centers for Youth and Families membership and waive and release any and all rights, causes of action and claims for damages I may have against the City of Boston, Boston Centers for Youth & Families, and any and all other associated individuals or organizations, arising out of any and all personal injuries or property damage which I may now or hereafter have as the parent or guardian of said minor, and also all rights, causes of action, and claims which said minor has or may acquire resulting from his/her participation in the program.

I give consent for me/my child to be administered first aid and to be treated by an emergency medical technician-paramedic, nurse or physician. Any follow up medical attention may be given at a local hospital and transportation to a Boston hospital is authorized. I give my consent for photographs, audiotapes, and video records of me/my child to be used by Boston Centers for Youth & Families for publicity purposes. I also agree to allow Boston Centers for Youth & Families to use photographs, audiotapes, video records or other work produced by the member for publicity purposes.

I understand that transportation is not provided and it is my responsibility to arrange transportation to and from Boston Centers for Youth & Families Community Centers.

Failure to comply with these rules and expectations can lead to termination of membership.

Signature of Member _____ Date _____

Signature of Member _____ Date _____

Signature of Member _____ Date _____

Signature of Parent/Guardian (if member is under 18) _____ Date _____