



Enrollment Date:	Start Date:	For Center Use Only Staff initials	Member No.
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TEEN PROGRAM Membership Application

Date _____

Member Type

- New Member
 Returning Member

PARENT/GUARDIAN CONTACT

- Role in Household**
- Mother Step-Parent Brother Grandparent Guardian
 Father Aunt/Uncle Cousin Foster Parent Other Relative

First Name _____

Last Name _____

Email Address _____

Phone _____

Mobile Phone _____

Address _____

City, State, Postal Code _____

MEMBER DETAILS

TEEN MEMBER Information

First Name _____

Middle Name _____

Last Name _____

Email address _____

Address _____

City, State, Postal code _____

Phone (mobile) _____

Birthdate _____

- Gender**
- Male Gender Queer Other
 Female Gender Non-Conforming Choose Not to Answer
 Trans Male
 Trans Female

- Pronouns**
- He, Him, His She, Her, Hers They, Them, Theirs

- Racial / Ethnic Identity**
- American Indian or Alaska Native Hispanic or Latino White
 Asian Middle Eastern or North African Bi-racial
 Black or African American Native Hawaiian or Other Pacific Islander Multi-Racial
 Other
 Choose Not to Answer



School Information

Grade _____

School Name _____

Guidance Counselor _____

Allergies

Food Allergies

<input type="checkbox"/> Peanuts	<input type="checkbox"/> Soy	<input type="checkbox"/> Eggs
<input type="checkbox"/> Tree Nuts	<input type="checkbox"/> Gluten	<input type="checkbox"/> Other _____
<input type="checkbox"/> Dairy/Lactose	<input type="checkbox"/> Seafood/Shellfish	

Environmental Allergies

<input type="checkbox"/> Bee Stings	<input type="checkbox"/> Dust	<input type="checkbox"/> Grass
<input type="checkbox"/> Pollen	<input type="checkbox"/> Mold	<input type="checkbox"/> Other _____

Other Allergies

<input type="checkbox"/> Latex	<input type="checkbox"/> Lotions
<input type="checkbox"/> Perfumes/Colognes	<input type="checkbox"/> Other _____

Medical Information

Diagnosed Medical Conditions

<input type="checkbox"/> Asthma	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Other _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Autism	
<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Seizures	
<input type="checkbox"/> Visual impairment	<input type="checkbox"/> Anxiety/Depression	
	<input type="checkbox"/> Oppositional Defiance Disorder	

Please list any other physical, mental or medical limitations/restrictions.

Does the member use an inhaler? Yes No

Does the member use insulin? Yes No

Does the member use an EpiPen? Yes No

Does the member self-administer medication? Yes No

Insurance

Insurance Carrier _____	Policy Holder _____
Group Number _____	Member/Policy Number _____
Doctor Name: _____	Doctor Phone Number: _____

AUTHORIZED CONTACTS

Authorized Contact 1	Authorized Contact 2
Full Name _____	Full Name _____
Phone _____	Phone _____
Mobile Phone _____	Mobile Phone _____
Work Phone _____	Work Phone _____
Emergency Contact <input type="checkbox"/> Yes <input type="checkbox"/> No	Emergency Contact <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____



NON-AUTHORIZED CONTACTS

Please list any individuals that are restricted from picking up the member.

Non-Authorized Contact 1		Non-Authorized Contact 2	
Full Name _____	Phone _____	Full Name _____	Phone _____
Relationship	<input type="checkbox"/> Parent / Stepparent <input type="checkbox"/> Grandparent <input type="checkbox"/> Other Relative <input type="checkbox"/> Friend <input type="checkbox"/> Other	Relationship	<input type="checkbox"/> Parent / Stepparent <input type="checkbox"/> Grandparent <input type="checkbox"/> Other Relative <input type="checkbox"/> Friend <input type="checkbox"/> Other
Start Date _____	End Date _____	Start Date _____	End Date _____

WAIVERS & RELEASES

Data Collection

Yes No I give my permission to the Boys & Girls Clubs of Gloucester County (BGCGC) to collect information via online or written surveys, questionnaires, interviews and focus groups from the minor child listed on this application. Any and all information received will be kept strictly confidential. Data gathered through these means will be summarized in the aggregate and will exclude all references to any individual responses. The aggregated results of these analyses may be shared with Club staff, BGCA, funders, and other community stakeholders to evidence program effectiveness and/or Club impact on our members. This release may be revoked at any time by contacting the BGCGC in writing.

Initial _____

Medical

Yes No I give permission to the Boys & Girls Clubs of Gloucester County to seek emergency medical treatment for my minor child if I cannot be reached. I will be responsible for any/all costs of medical attention and treatment.

Initial _____

Technology

Yes No As a member of the Boys & Girls Clubs of Gloucester County, our child may have access to the internet. While the Boys & Girls Club of Gloucester County has rules prohibiting such conduct and precautions are taken by the Club to prevent such access, it is possible your child may access inappropriate sites. The Boys & Girls Club of Gloucester County will not be responsible for such unauthorized access.

Initial _____

Transportation

Yes No Parents/Guardians and Club members may be responsible for their own transportation to and from the Club, unless otherwise specified.

Initial _____

Data Sharing

Yes No I give my permission to the BGCGC to share information about the minor child listed on this application with BGCA for research purposes and/or to evaluate the program's effectiveness. Information that will be disclosed to BGCA may include the information provided on this membership application form, information provided by the minor child's school or school district, and other information collected by BGCGC, including data collected via surveys or questionnaires. All information provided to BGCA will be kept confidential. This release may be revoked at any time by contacting the BGCGC in writing.

Initial _____



WAIVERS & RELEASES (Continued)

Press / Media

Yes No I give my permission for my child's picture, video image, or any other graphic depiction or likeness, to be used by Boys & Girls Clubs of Gloucester County, Boys & Girls Clubs of America and its affiliates or donors and acknowledge neither my child nor I will receive payment for same.

Initial _____

Miscellaneous

Yes No I understand that the Boys & Girls Clubs of Gloucester County is not responsible for lost or stolen items. Each Club has the right to make membership decisions based on the resources and capacity of their facility and staff. BGCGC reserves the right to decline the application, rescind the enrollment of, or suspend any youth that cannot successfully associate with other club members.

Initial _____

APPLICATION APPROVAL

I, the parent/guardian of the minor child listed on this application, on behalf of the minor child listed herein and for ourselves, our heirs, executors and administrators, hereby release, waive, acquit and forever discharge the Boys & Girls Clubs of Gloucester County, Inc. (BGCGC) and Boys & Girls Clubs of America (BGCA), their representatives, successors, insurers, assigns or any other person or entity associated with any of the above organizations such as staff, directors or volunteers, from all liability, claims, demands, or causes of action for any and all loss, damage, injury or death and any claim of damages resulting from use of facilities owned or controlled by the above organizations, or participation in activities of said organizations either at or away from the Club.

My signature below attests that all of the above information is correct. As a parent/guardian of the above participating child, I certify that he/she is in good physical health and may participate in all of the activities of the Boys & Girls Clubs of Gloucester County, except as noted above. I certify that I have read all of the above information and understand it fully.

Your signature below confirms that all information above is true and accurate.

Parent/Guardian Signature

Date