**Confidentiality:** Any confidential information requested is for our records and for the funding our organization receives. The answers you provide will be kept completely confidential. Your cooperation in providing this information is both appreciated and necessary. **Please be sure to update us immediatelywith any information that may change during the course of the year.**

**Head of Household Information (Please Print Legibly)**

Last Name:

First Name:

Gender

City

State

Zip Code

Address Line 2

Address Line 1

Address Type

* Home
* Work
* Other

Family Income

* Under $15,000
* $15,000-$19,000
* $20,000-$25,000
* $26,000-$32,000
* Over $32,000

Phone #: ( )  
 Home  Cell Work  Other

Ext

Phone #: ( )  
 Home  Cell Work  Other

Ext

Family Size

E-Mail Address:

E-Mail Type

* Home
* Work
* Other

Employer:

Job Title:

Occupation:

Is there a custody agreement for this child? Yes No

Work Schedule:

**Parent/Guardian/Other Adult Information (Please Print Legibly)**

First Name:

Last Name:

Address Type

* Home
* Work
* Other

Address Line 1

E-Mail Type

* Home
* Work
* Other

E-Mail Address:

Ext

Phone #: ( )  
 Home  Cell Work  Other

Phone #: ( )  
 Home  Cell \_Work  Other

Ext

Address Line 2

Zip Code

State

City

Gender

Family Size

Occupation:

Job Title:

Employer:

Work Schedule:

**Member Information (Please print legibly.)**

Middle Name:

P **Member**

**Check below if this information is the same as the parent information.**

Address Line 2

Address Line 1

Phone #: ( )

Home  Cell Work  Other



Phone #: ( )

Home  Cell Work  Other



* Acquaintance
* Relative
* Other \_\_\_\_\_\_\_\_\_\_\_
* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Emergency Contact
* Primary Emergency Contact
* Lives with Member
* Emergency Contact
* Primary Emergency Contact
* Lives with Member
* Acquaintance
* Relative
* Other \_\_\_\_\_\_\_\_\_\_\_
* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: ( )

Home  Cell Work  Other



Last Name:

First Name:

First Name:

Last Name:

**Pick-Up Information (Please print legibly.)**

Check all that apply

\_\_\_\_\_ TANF

\_\_\_\_\_ Food Stamps

\_\_\_\_\_ General Assistance

\_\_\_\_\_ SSDI

\_\_\_\_\_ SSI

\_\_\_\_\_ Veterans Compensation

\_\_\_\_\_ Day Care Voucher

\_\_\_\_\_ Free/Reduced Lunch

\_\_\_\_\_ Medicaid

Zip Code

City

State

Household Type

\_\_\_ Lives w/Both Parents \_\_\_Lives w/Grandparents

\_\_\_ Lives w/Mother \_\_\_ Lives w/Aunt/Uncle

\_\_\_ Lives w/Father \_\_\_ Lives w/Guardian

\_\_\_ Lives w/Mother and Step Parent

\_\_\_ Lives w/Father and Step Parent

Membership Type

\_\_\_\_\_After School \_\_\_\_\_ Summer Camp

Gender

\_\_\_\_\_ Male

\_\_\_\_\_ Female

Ethnicity

\_\_\_\_\_ African American \_\_\_\_\_Multi-Racial

\_\_\_\_\_ Asian \_\_\_\_\_ Hispanic

\_\_\_\_\_ Caucasian \_\_\_\_\_Native American

Grade:

Teacher:

School:

Birth Date:

How long in Richland County?:

Nick Name:

Last Name:

First Name:

**Medical Information (Please print legibly.) PLEASE INDICATE IF THIS INFORMATION IS DIFFERENT FOR YOUR OTHER CHILD(REN).**

Physician

Physician Phone

( )

Medications

Medical Problems/Behavioral Problems/Allergies

Disabilities/IEP

Insurance Company and Policy/Group #

**Please check the following resources we can release and obtain confidential information about your child. PLEASE INDICATE IF THIS INFORMATION IS DIFFERENT FOR YOUR OTHER CHILD(REN).**

* Richland County School Personnel
* Childcare Provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Mental Health Agency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Medical Personnel \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BGCRC also uses the following information to learn more about your child. Please check one item from each group below. PLEASE INDICATE IF THIS INFORMATION IS DIFFERENT FOR YOUR OTHER CHILD(REN).**

Public Housing:

* No
* Yes

Homework:

* No, only at home
* Yes, must do at the Club
* Periodically, as needed

Single Parent:

* No
* Yes

Can Walk Home:

* Must Call
* No
* Yes

**Travel Permission Authorization**

I hereby give my son/daughter (circle one) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ permission to travel to Boys & Girls Club sponsored events whether on foot or by other modes of transportation, i.e. Richland County Transportation or chartered bus. **Please list any other children here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Waiver of Liability and Disclaimer:** In consideration of my son’s daughter’s membership and participation in BGCRC, I, as parent/ guardian of named minor, waive, release and discharge any and all rights and claims of damages against BGCRC and/or its sponsors for all claims arising from traveling, participating, and/or being involved in the program/activities. I attest and verify that I have full knowledge of the risks involved in said participation and that I will on behalf of the said member assume and pay any medical or emergency expenses in the event of accident, illness or other incapacity regardless of whether I have authorized such expenses. I attest that my son/daughter is physically fit and sufficiently able to participate in the programs/ activities of the BGCRC in conjunction with other youth members. If there are inabilities, beliefs or disabilities that would inhibit participation, I will disclose on the membership application and notify staff as activities come up.

**Acknowledgement and Consent**: I acknowledge that the BGCRC and/or its sponsors may utilize photographs of the member which may be taken during involvement in the BGCRC program/activities and that some of these photographs may be used on the Club website or Facebook page. I consent to such uses and hereby waive all rights to compensation.

**Emergency Authorization**: I, the undersigned or as parent/guardian of the participant, a minor, herby authorize the staff of BGCRC or its sponsors, volunteers, coaches, trainers, activity supervisors, instructors, and vehicle drivers as my agents to consent to medical surgical or dental examination and/or treatment. In case of emergency, I hereby authorize treatment and/or care at any hospital or licenses medical facility. Club staff WILL NOT medicate children. Parents/guardians are ENTIRELY responsible for medications and for personally arranging for or ensuring the proper and timely medicating of their children. Any medications needed for emergency situations that my child has prescribed to them will be discussed and given to the Program Director, as well as plans discussed for disposal at the end of the program year or when medication is expired.

**Your signature acknowledges that you have read and accepted the policies of the Club as described above and in the Parent/Member Handbook.**

**Child(ren)’s Name or Names \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please list all children who attend the Club above.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Date Signature Relationship**

**Membership Information Form (Additional Child)**

**Head of Household (Please print legibly.)**

First Name:

Last Name:

Gender

**Member Information (Please print legibly.)**

First Name:

Last Name:

Nick Name:

Birth Date:

How long in Richland County?:

School:

Teacher:

Grade:

Gender

\_\_\_\_\_ Male

\_\_\_\_\_ Female

Ethnicity

\_\_\_\_\_ African American \_\_\_\_\_Multi-Racial

\_\_\_\_\_ Asian \_\_\_\_\_ Hispanic

\_\_\_\_\_ Caucasian \_\_\_\_\_Native American

Household Type

\_\_\_ Lives w/Both Parents \_\_\_Lives w/Grandparents

\_\_\_ Lives w/Mother \_\_\_ Lives w/Aunt/Uncle

\_\_\_ Lives w/Father \_\_\_ Lives w/Guardian

\_\_\_ Lives w/Mother and Step Parent

\_\_\_ Lives w/Father and Step Parent

Membership Type

\_\_\_\_\_After School \_\_\_\_\_ Summer Camp

Middle Name:

**Pick-Up Information (If different from other children)**

Last Name:

Is there a custody agreement for this child? Yes No

Phone #: ( )

 Home  Cell Work  Other

First Name:

Last Name:

First Name:

Last Name:

Phone #: ( )

 Home  Cell Work  Other

* Acquaintance
* Relative
* Other \_\_\_\_\_\_\_\_\_\_\_
* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Emergency Contact
* Primary Emergency Contact
* Lives with Member
* Acquaintance
* Relative
* Other \_\_\_\_\_\_\_\_\_\_\_
* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Emergency Contact
* Primary Emergency Contact
* Lives with Member