YMCA of Honolulu

2010 Programs Registration Form

Moanalua Community Park - Summer Plus

PLEASE TYPE OR PRINT CLEARLY IN BLACK INK. COMPLETE THIS FORM, AND SUBMIT IT TO THE KALIHI YMCA BRANCH.

PARTICIPANT'S NAME: FAMILY/LAST	FIRST/GIVEN	MIDDLE INITIAL

GENDER	BIRTHDATE	GRADE	SCHOOL	YMCA BRANCH
❑ FEMALE ❑ MALE	______ / ______ / ______	(must have completed Kindergarten)		

CURRENT MAILING ADDRESS – NUMBER STREET	CITY	STATE	ZIP CODE	HOME PHONE

PARTICIPANT RESIDES WITH

❑ MOTHER ❑ FATHER ❑ BOTH PARENTS ❑ OTHER: ______________________________

FATHER/LEGAL GUARDIAN'S NAME (LAST, FIRST)	OCCUPATION	BUS. PHONE	CELL PHONE
MOTHER/LEGAL GUARDIAN'S NAME (LAST, FIRST)	OCCUPATION	BUS. PHONE	CELL PHONE

EMAIL ADDRESS (Important for online registration/e-bulletins)	YOUTH CELL PHONE (For teen participant's only)	NAME(S) SIBLINGS IN PROGRAM

PHYSICIAN	CHOICE OF HOSPITAL	OFFICE PHONE	CELL PHONE

PLEASE LIST ANY PHYSICAL OR OTHER LIMITATIONS THAT MIGHT HINDER YOUR CHILD'S PARTICIPATION

PLEASE LIST ANY SPECIAL REQUIREMENTS OR CONDITIONS (list medication, dosage, times to be taken, vegetarian meals, and or allergies)

In addition to the parents/legal guardians, I authorize the following people to pick up my child(ren) and/or be contacted in an emergency if the parent/legal guardian cannot be contacted.

NAME	RELATIONSHIP	HOME PHONE	CELL PHONE	WORK PHONE
NAME	RELATIONSHIP	HOME PHONE	CELL PHONE	WORK PHONE
NAME	RELATIONSHIP	HOME PHONE	CELL PHONE	WORK PHONE

RELEASE WAIVERS

I also authorize the YMCA of Honolulu to use the name and any video/photographs/audio taken of my participant and/or myself at anytime or in any manner in connection with its advertising, publicity and public relations programs. The YMCA may only use the video/photographs/audio. I will make no further claims.

PARENT GUARDIAN NAME (PRINT) ______________ PARENT/GUARDIAN SIGNATURE ______________ DATE ______________

MEDICAL CARE AUTHORIZATION

If in the judgment of the YMCA staff, my child/teen requires medical care, I authorize and instruct the YMCA to inform me or the authorized person listed above. The YMCA may take my child/teen in for medical treatment to the physician, hospital or clinic, I or the authorized person designated. If the authorized person, the physician, or I can't be promptly reached, I authorize the YMCA to take my child/teen to the nearest hospital or clinic for such medical treatment.

My child/teen is covered by:

NAME OF MEDICAL INSURER ______________ CARD/POLICY NUMBER ______________

PARENT/GUARDIAN'S SIGNATURE ______________ DATE ______________

FOR YMCA OFFICE USE ONLY

CHECK ALL THAT APPLY

❑ CLASS Input