

# Catskill Community Center Program Registration Form

Complete and bring this form to your school office or the Catskill Community Center

Date (completing form): \_\_\_\_\_

Program registering for: \_\_\_\_\_

Name of Participant \_\_\_\_\_ T-Shirt Size \_\_\_\_\_

Family Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

## Child's Information:

Gender \_\_\_\_\_ Ethnicity \_\_\_\_\_

(This helps when applying for grants.)

Date of Birth \_\_\_\_\_ Age (as of the date of this application): \_\_\_\_\_

Entering Grade/Current Grade: \_\_\_\_\_

## Medical History & Allergies Information

*Please check and give approximate dates when applicable:*

### Allergies

\_\_\_\_ Hay Fever

\_\_\_\_ Poison Ivy/Oak

\_\_\_\_ Insect Stings

\_\_\_\_ Penicillin

### Conditions

\_\_\_\_ Diabetes

\_\_\_\_ Asthma

\_\_\_\_ Other: Please explain \_\_\_\_\_

Does your child currently use any medications? If so please list: \_\_\_\_\_

Does your child have any medical conditions that may make it difficult to participate in the program for which you are registering? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes please explain \_\_\_\_\_

**Information About the Family**

*Please check the parent to be notified in the event of emergency*

\_\_\_\_ Mother/Guardian's Name\_\_\_\_\_

Street Address\_\_\_\_\_

City\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_

Home Phone\_\_\_\_\_ Cell Phone\_\_\_\_\_ Office\_\_\_\_\_

E-Mail\_\_\_\_\_ Employer\_\_\_\_\_

\_\_\_\_ Father/Guardian's Name\_\_\_\_\_

Street Address\_\_\_\_\_

City\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_

Home Phone\_\_\_\_\_ Cell Phone\_\_\_\_\_ Office\_\_\_\_\_

E-Mail\_\_\_\_\_ Employer\_\_\_\_\_

**Emergency Care Information**

Name of child's Doctor\_\_\_\_\_

Street Address\_\_\_\_\_

City\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_

Phone Number\_\_\_\_\_

Name of child's Dentist\_\_\_\_\_

Street Address\_\_\_\_\_

City\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_

Phone Number\_\_\_\_\_

Hospital Preference\_\_\_\_\_

Insurance Company\_\_\_\_\_ Policy Number\_\_\_\_\_

Street Address\_\_\_\_\_

City\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_

**Emergency Contact – Authorized to pick up Child**

Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Is there anyone who is NOT to pick up your child?    \_\_\_ Yes    \_\_\_ No

If so please provide name and a copy of Court Order (if needed) \_\_\_\_\_