girls inc.

Member Information Sheet

UNIQUE ID

EXPIRATION DATE

Child's Name _____
First Last Nickname

Street Address (or PO Box) _____ Home Phone _____

City _____ State _____ Zip _____ County _____

Age _____ Birthdate _____ Grade _____ School _____ Social Security # _____

Physician Name _____ Phone _____ Hospital _____

Insurance Carrier _____ Policy # _____ Group # _____

Medical/Physical Information:

- ☐ Emotional
- ☐ Visual
- ☐ Multiple
- ☐ Mobility
- ☐ Other Physical
- ☐ Learning
- ☐ Hidden Health
- ☐ Developmental
- ☐ Hearing
- ☐ Other Disabilities

Allergies: _____

Racial/Ethnic Profile

- ☐ African American
- ☐ Hispanic
- ☐ Native American
- ☐ White/Anglo
- ☐ Asian American
- ☐ Multiracial
- ☐ Pacific Islander
- ☐ Other

Receives free or reduced rates on the school lunch program? ☐ Yes ☐ No

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☐ mother
☐ father
☐ guardian

Name _____ Address _____ (if different from above)

Employed by _____ Work Phone _____ Cell Phone _____

E-mail address _____

Racial/Ethnic Profile

☐ African American ☐ Asian American ☐ Hispanic ☐ Multiracial ☐ Native American ☐ Pacific Islander ☐ White/Anglo ☐ Other

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☐ mother
☐ father
☐ guardian

Name _____ Address _____ (if different from above)

Employed by _____ Work Phone _____ Cell Phone _____

E-mail address _____

Racial/Ethnic Profile

☐ African American ☐ Asian American ☐ Hispanic ☐ Multiracial ☐ Native American ☐ Pacific Islander ☐ White/Anglo ☐ Other

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Additional Emergency Contact: _____ Relationship _____

Telephone #1 _____ Telephone #2 _____

Household Information

Household Income

- ☐ $10,000 or less
- ☐ $10,000 - 15,000
- ☐ $15,000 - 20,000
- ☐ $20,000 - 25,000
- ☐ $25,000 +

Primary language spoken in the home

- ☐ English
- ☐ Vietnamese
- ☐ Spanish
- ☐ Other

Parents separated? ☐ no ☐ yes

If yes, child lives with: ☐ Mother ☐ Father ☐ Other ☐ Joint Custody

Media Release

I hereby give the Girls Incorporated of Fort Smith and participating agencies permission to use film, video tape and/or photographs of the above mentioned minor for lawful promotional or informational purposes.

Medical Waiver

In case of medical or surgical emergency, after every reasonable effort has been made to contact the parent or legal guardian, I hereby give my permission to the physician selected by the center director to provide whatever emergency or surgical treatment is necessary for the above referenced child.

Signature _____ Date _____

All Information is Confidential

The statistics (not the names) are used in applying for various grants and donations. Please help us by filling out as much information as possible.

4/05