



Has your child ever been a member of a Club?	Membership ID	MEMBERSHIP DATES (Staff Only)	
<input type="checkbox"/> No <input type="checkbox"/> Yes – Where?	<input type="text"/>	Service:	<input type="text"/>
<input type="checkbox"/> Renewing <input type="checkbox"/> Former <input type="checkbox"/> New <input type="checkbox"/> Transfer	Receipt #:	Termination:	<input type="text"/>
	<input type="text"/>	Initial:	<input type="text"/>
		Renewal:	<input type="text"/>

HEAD OF HOUSEHOLD (Please Print)

LAST Name:	FIRST Name:	Gender:	Household Income:
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> under \$20,000 <input type="checkbox"/> under \$30,000 <input type="checkbox"/> under \$40,000 <input type="checkbox"/> under \$50,000 <input type="checkbox"/> under \$60,000 <input type="checkbox"/> under \$70,000 <input type="checkbox"/> under \$80,000 <input type="checkbox"/> under \$90,000 <input type="checkbox"/> under \$100,000 <input type="checkbox"/> over \$100,000
Address:		Address Type:	
<input type="text"/> (Line 1)		<input type="checkbox"/> Home	
<input type="text"/> (Line 2)		<input type="checkbox"/> Work	
<input type="text"/> (City)		<input type="checkbox"/> _____	
<input type="text"/> (State)	<input type="text"/> (Zip)	# in Household:	
Contact Information:		over 18 _____ under 18 _____	
<input type="text"/> (Home) () -	<input type="text"/> (Cell) () -	Military Family:	
<input type="text"/> (Work) () -	<input type="text"/> (Email)	<input type="checkbox"/> YES (Branch) <input type="checkbox"/> NO	
Employer:	Job Title:	Occupation:	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

2ND PARENT/GUARDIAN (Please Print)

LAST Name:	FIRST Name:	Gender:	Household Income:
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> under \$20,000 <input type="checkbox"/> under \$30,000 <input type="checkbox"/> under \$40,000 <input type="checkbox"/> under \$50,000 <input type="checkbox"/> under \$60,000 <input type="checkbox"/> under \$70,000 <input type="checkbox"/> under \$80,000 <input type="checkbox"/> under \$90,000 <input type="checkbox"/> under \$100,000 <input type="checkbox"/> over \$100,000
Address:		Address Type:	
<input type="text"/> (Line 1)		<input type="checkbox"/> Home	
<input type="text"/> (Line 2)		<input type="checkbox"/> Work	
<input type="text"/> (City)		<input type="checkbox"/> _____	
<input type="text"/> (State)	<input type="text"/> (Zip)	# in Household:	
Contact Information:		over 18 _____ under 18 _____	
<input type="text"/> (Home) () -	<input type="text"/> (Cell) () -	Military Family:	
<input type="text"/> (Work) () -	<input type="text"/> (Email)	<input type="checkbox"/> YES (Branch) <input type="checkbox"/> NO	
Employer:	Job Title:	Occupation:	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

MEMBER INFORMATION (Please Print)

LAST Name: <input style="width:95%;" type="text"/>	FIRST Name: <input style="width:95%;" type="text"/>	MIDDLE Name: <input style="width:95%;" type="text"/>
Nick Name: <input style="width:95%;" type="text"/>	Birth Date: (Month) (Day) (Year)	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Ethnicity: <input type="checkbox"/> African American <input type="checkbox"/> Asian American <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Native American <input type="checkbox"/> Other _____	
Membership Type: <input type="checkbox"/> Full Time <input type="checkbox"/> Full Scholarship <input type="checkbox"/> Partial Scholarship	School: <input style="width:95%;" type="text"/>	Grade: <input style="width:95%;" type="text"/>
Pick Up Authorization Password: <input style="width:95%;" type="text"/>		Graduation Date: (H.S.) <input style="width:95%;" type="text"/>
Household Type – Check all that apply: <input type="checkbox"/> Mother <input type="checkbox"/> Step-Mother <input type="checkbox"/> Other <input type="checkbox"/> Father <input type="checkbox"/> Step-Father <input type="checkbox"/> Foster <input type="checkbox"/> Grandparents	Check all that apply: <input type="checkbox"/> TANF <input type="checkbox"/> Food Stamps <input type="checkbox"/> General Assistance <input type="checkbox"/> SSDI <input type="checkbox"/> SSI <input type="checkbox"/> Veterans Compensation <input type="checkbox"/> Day Care Voucher <input type="checkbox"/> Free/Reduced Lunch <input type="checkbox"/> Medicaid <input type="checkbox"/> None Apply	Can Swim: <input type="checkbox"/> YES <input type="checkbox"/> NO
Family Setting: <input type="checkbox"/> Foster <input type="checkbox"/> One Parent Family <input type="checkbox"/> Two Parent Family <input type="checkbox"/> Guardian <input type="checkbox"/> Other	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced	
Member Address:		
<input style="width:95%;" type="text"/> (Line 1)		
<input style="width:95%;" type="text"/> (Line 2)		
<input style="width:95%;" type="text"/> (City)	<input style="width:95%;" type="text"/> (State)	<input style="width:95%;" type="text"/> (Zip)
Phone Numbers:		
<input style="width:95%;" type="text"/> (Home) () -		<input style="width:95%;" type="text"/> (Cell) () -

MEDICAL INFORMATION (Please Print)

Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No		Medical Problems/Allergies/Disabilities: <input style="width:95%; height: 60px;" type="text"/>
Insurance Carrier _____ Policy # _____ Permission to be treated by Doctor or Hospital <input type="checkbox"/> YES <input type="checkbox"/> NO		
Physician: <input style="width:95%;" type="text"/>	Physician Phone: () -	Medications: <input style="width:95%; height: 60px;" type="text"/>
Hospital: <input style="width:95%;" type="text"/>	Hospital Phone: () -	

EMERGENCY CONTACT INFORMATION (Please Print)

1. First Name: <input style="width:95%;" type="text"/>	Last Name: <input style="width:95%;" type="text"/>	2. First Name: <input style="width:95%;" type="text"/>	Last Name: <input style="width:95%;" type="text"/>
<input type="checkbox"/> Lives with Member <input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Lives with Member <input type="checkbox"/> Male <input type="checkbox"/> Female	
Phone _____ Cell _____		Phone _____ Cell _____	
Address _____		Address _____	

I have read the completed application, understand the rules of Boys & Girls Clubs of Greater Northwest Indiana and give permission for my child(ren) to be admitted into membership. I have explained the rules to my child(ren) and agree that the Club will not be responsible for any accident to the child(ren) while on the Club's premises or while engaged in any of its activities away from BGCGNWI. I understand that information in this application is confidential. I will provide verification upon request by the Club. I give my full permission and consent to BGCGNWI to use and keep my child(ren)'s artwork; photographs or moving pictures they may take or produce at the Club' or photographs or moving pictures in which my child(ren) may appear. Refunds will only be issued three days after date of collection because the fee paid does not reflect the true cost of program services offered to members.

Parent/Guardian Signature_____
Club Member's Signature_____
Date