



**YMCA of Honolulu
Youth Programs Registration Form**

PLEASE TYPE OR PRINT CLEARLY IN INK. COMPLETE THIS FORM, AND SUBMIT IT TO YOUR LOCAL YMCA BRANCH.

PROGRAM CHOICE		SESSION/DATES		BARCODE(S)	
_____		_____		_____	
_____		_____		_____	
_____		_____		_____	
LEGAL NAME: FAMILY/LAST			FIRST/GIVEN		MIDDLE INITIAL
GENDER	BIRTHDATE		SCHOOL	GRADE	YMCA BRANCH
<input type="checkbox"/> FEMALE	month / day / year		_____	_____	_____
<input type="checkbox"/> MALE	____ / ____ / ____		_____	_____	_____
CURRENT MAILING ADDRESS – NUMBER STREET			CITY	STATE	ZIP CODE
_____			_____	_____	_____
					HOME PHONE:
					CELL PHONE:
EMAIL ADDRESS <i>(Used for Online Registration and E-Bulletins)</i>			NAME(S) OF OTHER SIBLINGS IN PROGRAM		
_____			_____		
PARTICIPANT RESIDES WITH					
<input type="checkbox"/> MOTHER	<input type="checkbox"/> FATHER	<input type="checkbox"/> BOTH PARENTS	<input type="checkbox"/> OTHER: _____		
FATHER'S NAME (LAST, FIRST)		OCCUPATION		BUS. PHONE	ALT. PHONE
_____		_____		_____	_____
MOTHER'S NAME (LAST, FIRST)		OCCUPATION		BUS. PHONE	ALT. PHONE
_____		_____		_____	_____
EMERGENCY CONTACT/AUTHORIZED PICK UP		RELATIONSHIP		PHONE	ALT. PHONE
_____		_____		_____	_____
EMERGENCY CONTACT/AUTHORIZED PICK UP		RELATIONSHIP		PHONE	ALT. PHONE
_____		_____		_____	_____
EMERGENCY CONTACT/AUTHORIZED PICK UP		RELATIONSHIP		PHONE	ALT. PHONE
_____		_____		_____	_____
PHYSICIAN		CHOICE OF HOSPITAL		PHONE	ALT. PHONE
_____		_____		_____	_____
PLEASE LIST ANY PHYSICAL OR OTHER LIMITATIONS THAT MIGHT HINDER YOUR CHILD/TEEN'S PARTICIPATION					

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

How did you hear about our program(s)?					
<input type="checkbox"/> Ad/Brochure/Postcard/Flyer	<input type="checkbox"/> Web	<input type="checkbox"/> Radio/TV	<input type="checkbox"/> OTHER: _____		
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					
<input type="checkbox"/> CLASS Input					