YMCA of Honolulu
REGISTRATION FORM

Please type or print clearly in ink. Complete this form and submit it to your local YMCA branch.

PROGRAM NAME	PROGRAM DATES	FEE

ACCOUNT INFORMATION

CHILD'S LAST NAME	FIRST NAME	BIRTH DATE	CURRENT GRADE	GENDER
PARENT LAST NAME (MAIN CONTACT)	FIRST NAME	GENDER	CELL PHONE	
PARENT LAST NAME	FIRST NAME	GENDER	CELL PHONE	
CURRENT MAILING ADDRESS (NUMBER / STREET)	CITY		STATE	ZIP CODE
HOME PHONE	EMAIL ADDRESS *(Used for online registration and e-bulletins)*			
EMERGENCY CONTACT / AUTHORIZED FOR PICK-UP (OTHER THAN PARENTS)	RELATIONSHIP	PHONE	ALT. PHONE	
EMERGENCY CONTACT / AUTHORIZED FOR PICK-UP (OTHER THAN PARENTS)	RELATIONSHIP	PHONE	ALT. PHONE	
EMERGENCY CONTACT / AUTHORIZED FOR PICK-UP (OTHER THAN PARENTS)	RELATIONSHIP	PHONE	ALT. PHONE	
PHYSICIAN	CHOICE OF HOSPITAL	PHONE	ALT. PHONE	

PLEASE LIST ANY PHYSICAL OR OTHER LIMITATIONS THAT MIGHT HINDER PARTICIPATION:

PLEASE LIST ANY SPECIAL REQUIREMENTS OR CONDITIONS:

HOW DID YOU HEAR ABOUT OUR PROGRAMS?

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) 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 me 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. **I am covered by:**

NAME OF MEDICAL INSURER CARD / POLICY NUMBER

SIGNATURE DATE

FOR YMCA OFFICE USE ONLY

CHECK ALL THAT APPLY: ☐ CLASS Input