Brainerd Family YMCA • 2018-201					•
PLEASE USE ONE FORM PER CHILD AND PR	INT NEATLY.	Date C	Completed		
Child's First Name Middle In	tial Last Name (if di	ifferent)		Birthdate _	
Gender □F □M Grade in fall 2018	Age Name of Sc	chool Attend	ing in 2018-1	2019	
Child resides with \(\text{Mother} \) \(\text{Father} \) \(\text{Both} \) #1 Parent/Guardian's First Name	□Other		Are you a `	YMCA member? [∃Yes □No
#1 Parent/Guardian's First Name	Middle Initi	al	Last Name_		
Address Cit	/	_ State	Zip		_
Home Phone () E-ma	il				
Parent/Guardian's Work Phone ()	Cell Ph	none ()		
F-Maii annress					
#2 Parent/Guardian's First Name	Middle	Initial	Last		
Name					
Address	City		Sta	ite	
Zip Home Phone () E-ma Parent/Guardian's Work Phone ()	il				
Parent/Guardian's Work Phone ()	Cell Pho	ne ()		
E-mail address	cen rno	me (_/		
EMERGENCY CONTACTS AND PICK-UP AUTH	OPIZATION - The follo	wing peop	e should be	a contacted in c	ase of
emergency, only if parent or guardian cann					ase or
1. Name Cell (_	Relationsh	ip to child			
Phone: Day () Cell (_)				
2. Name		Relatioi	isnip to		
child	; .				
Phone: Day () Cell (
Family Doctor	Phone ()			
Family Dentist					
Do you carry family medical/hospital insurance?	☐Yes ☐No Carrier			Policy/Group)
#					
IS THE CHILD TAKING ANY MEDICATIONS?	□Yes □No				
If yes, what kind and why:					
		–	–		
If medication needs to be administered dur	ing the program, a Med	lication Pe	rmission Fo	rm must be cor	npieted.
If medication needs to be administered dur HAS CHILD HAD ANY OF THE FOLLOWING,			rmission Fo	rm must be cor	npieted.
HAS CHILD HAD ANY OF THE FOLLOWING,	AND IF SO, PLEASE EXP	PLAIN:			_
HAS CHILD HAD ANY OF THE FOLLOWING, A □ Special needs	AND IF SO, PLEASE EXP □Allergies or A	<mark>PLAIN:</mark> Asthma			
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