

<b>MEMBERSHIP APPLICATION</b>	
<b>Program Year</b> _____	
Registration Hours:  Monday – Friday 1pm – 7pm	<input type="checkbox"/> ANNUAL FEE \$5.00  <input type="checkbox"/> SUMMER FEE \$25.00

**Required Registration Documents**

- ✓ Original Birth Certificate/Passport
- ✓ Updated Immunization Records
- ✓ Physical Examination Form (signed, dated, and stamped)
  - Prior physical dated no more than two years  
OR
  - New physical form included in this packet

**Clubhouse Affiliation**

Marion McMahon Abbe  
133-01 41st Road  
Flushing, NY 11355  
718.886.5454

Elbridge T. Gerry, Jr.  
321 East 111<sup>th</sup> Street  
New York, NY 10029  
212.534.2661

Harriman  
287 East 10<sup>th</sup> Street  
New York, NY 10009  
212.533.2550

<input type="checkbox"/> New Member	Age _____	Grade _____
<input type="checkbox"/> Returning Member	Age _____	Grade _____

<b><u>OFFICE USE ONLY:</u></b>		
<input type="checkbox"/> <b>Explorer:</b> K (age 6) – 4 <sup>th</sup>	<input type="checkbox"/> <b>Junior:</b> 5 <sup>th</sup> – 8 <sup>th</sup>	<input type="checkbox"/> <b>Senior:</b> 9 <sup>th</sup> +
<input type="checkbox"/> <b>Alumni</b> (age 21+) complete Alumni Registration Form		

**Please PRINT CLEARLY**

APPLICANT INFORMATION				
Member's Last Name:		First Name:		Nickname:
Current Address:				Apt#
City:		State:	Zip Code:	
Birthday:			Age:	
Ethnicity:    ___ African-American    ___ Asian    ___ Caucasian    ___ Hispanic				
MOTHER/GUARDIAN'S INFORMATION				
Mother/Guardian's Name:				
Address:				
Street		Apt#	City	State      Zip Code
Home Phone:		Cell Phone:	Work Phone:	
Email Address:				
Current Employer:			Position Held:	
Address:				
FATHER/GUARDIAN'S INFORMATION				
Father/Guardian's Name:				
Address:				
Street		Apt#	City	State      Zip Code
Home Phone:		Cell Phone:	Work Phone:	
Email Address:				
Current Employer:			Position Held:	
Address:				
EMERGENCY CONTACTS				
Name:		Name:		
Relationship:		Relationship:		
Address:		Apt#:	Address:      Apt#:	
City:	State:	Zip Code:	City:	State:      Zip Code:
Phone:		Alt. Phone:	Phone:      Alt. Phone:	
PERSON(S) AUTHORIZED TO ESCORT MEMBER FROM CLUBHOUSE				
Name/ Phone#:		Name/Phone#:		
MEMBER'S EDUCATION				
School:		Grade:	Teacher:	
ALLERGIES/MEDICAL INFORMATION				
Allergies/Medical Conditions:		Medications:		
Doctor:		Preferred Hospital:		
Insurance Company:		Insurance Policy Number:		

<b>FAMILY INCOME</b>
<b>Please check your Family Income</b>
<input type="checkbox"/> \$12,740 or below
<input type="checkbox"/> \$12,741 - \$17,160
<input type="checkbox"/> \$17,161 - \$21,580
<input type="checkbox"/> \$21,581 - \$26,000
<input type="checkbox"/> \$26,001 - \$30,420
<input type="checkbox"/> \$30,421 - \$34,840
<input type="checkbox"/> \$34,841 - \$39,260
<input type="checkbox"/> \$39,261 - \$43,680
<input type="checkbox"/> \$43,681 or above
<b>HOUSEHOLD TYPE</b>
<input type="checkbox"/> 1 Parent Family
<input type="checkbox"/> 2 Parent Family
<input type="checkbox"/> Foster Care
<input type="checkbox"/> Guardianship
<b>HOUSEHOLD SIZE</b>
Family Size _____
# of Adults _____
# of Children _____

<b>OFFICE USE ONLY:</b>
<input type="checkbox"/> <b>New</b>
<input type="checkbox"/> <b>Renew</b>
Registration Date ____/____/____
<input type="checkbox"/> <b>Explorer</b>
<input type="checkbox"/> <b>Junior</b>
<input type="checkbox"/> <b>Intermediate</b>
<input type="checkbox"/> <b>Senior</b>
ID# _____
<input type="checkbox"/> Birth Certificate/ Passport
<input type="checkbox"/> Immunization
<input type="checkbox"/> Physical Date _____
<input type="checkbox"/> Medical Release

I have read the completed application; the proposed member and I understand the rules of The Boys' Club of New York and I request that he be admitted into membership. On his behalf I hereby release, discharge, indemnify and hold harmless The Boys' Club of New York, and any of its affiliates, subsidiaries, officers, agents and employees, from all claims, demands, actions, or liabilities of whatever kind and nature, including but not limited to bodily injury, death or property damage arising from, or in any way connected to, such child's use, operation, or participation in Boys' Club activities. I hereby give my permission for photographs and videos of him to be used in The Boys' Club of New York promotional materials and website.

\_\_\_\_\_  
**PARENT/GUARDIAN SIGNATURE**

\_\_\_\_\_  
**MEMBER'S SIGNATURE**

\_\_\_\_\_  
**DATE**

See INSTRUCTIONS on reverse.

**CHILD CARE CENTER NAME:** \_\_\_\_\_

Print the name of the child(ren) enrolled in this child care center:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

**DIRECTIONS:**

**Complete SECTION A if anyone in your household:**

1. Receives Food Stamps
2. Receives Temporary Assistance to Needy Families (TANF)
3. Participates in the Food Distribution Program on Indian Reservations (FDPIR)
4. Currently has a foster child enrolled in day care

<b>SECTION A</b>
Food Stamp Case Number _____
TANF Number _____
FDPIR Number _____
Foster Child's Name _____
Foster Child's Personal Monthly Income \$ _____
<p><b>An adult household member must sign the application before it can be approved.</b> After reading the following statement and the statement on the back, sign below.</p> <p>I certify that the above information is true and correct and that all income is reported. I understand this information is being given for the receipt of Federal funds, that officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.</p>
Signature: _____
Date: _____
<b>FOR SPONSOR USE ONLY</b>
Sponsor Agreement Number _____
Total Household Members _____
Total Income \$ _____
Free _____ Reduced _____ Paid _____
Signature of Determining Official _____
Date Determined ____ / ____ / ____

**Complete SECTION B if SECTION A does not apply:**

Sign, date and indicate the Social Security number of the adult signing the certification and return the completed form to the day care center.

<b>SECTION B</b>	
<p>List all household members below. Include yourself and all adults and children NOT listed above, even if they do not receive income. Then list all income received <b>last month</b> in your household in the column to the right. Gross income includes: earnings from work, pensions, retirement, Social Security, welfare payments, child support and any other sources of income.</p>	
Name of Household Members	Monthly Gross Income
1. _____	\$ _____
2. _____	\$ _____
3. _____	\$ _____
4. _____	\$ _____
5. _____	\$ _____
6. _____	\$ _____
<p><b>An adult household member must sign the application before it can be approved.</b> After reading the following statement and the statement on the back, sign below.</p> <p>I certify that the above information is true and correct and that all income is reported. I understand this information is being given for the receipt of Federal funds, that officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.</p>	
Signature: _____	
Print Name: _____	
SS# _____	Date: _____

## **Section 9**

Unless you list the Food Stamp, TANF or FDPIR number for the child or a household member or are applying for a foster child, Section 9 of the National School Lunch Act requires that you include the Social Security Number of the household member signing the application or indicate that the household member signing the application does not have a Social Security Number. You do not have to list a Social Security Number, but if a Social Security Number is not listed or an indication is not made that the adult household member signing the application does not have a Social Security Number, CACFP cannot approve the application. The Social Security Number may be used to verify the correctness of the information stated on the application. This may include program reviews, audits and investigations and may include contacting employers to determine income, contacting a Food Stamp, TANF or FDPIR office to determine current certification for Food Stamp, TANF or FDPIR benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims or legal actions if incorrect information is reported.

### **Definition of Income**

*Income* means income before deductions for income taxes, social security taxes, insurance premiums, charitable contributions, and bonds, etc. It includes the following: (1) monetary compensation for services, including wages, salary, commissions or fees; (2) net income from non-farm self-employment; (3) net income from farm self-employment; (4) social security payments; (5) dividends or interest on savings or bonds, income from estates or trusts or net rental income; (6) public assistance or welfare payments; (7) unemployment compensation; (8) government civilian employee or military retirement, or pensions or veteran's payments; (9) private pensions or annuities; (10) alimony or child support payments; (11) regular contributions from persons not living in the household; (12) net royalties; (13) military benefits received in cash, such as housing allowance; and (14) any other cash income.

### **Definition of Household**

Household means *family* as defined in Section 226.2. *Family* means a group of related or non-related individuals who are not residents of an institution or boarding house, but who are living as one economic unit.

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## **INSTRUCTIONS FOR COMPLETING DOH-3688**

### **Instructions for Parents or Guardians:**

Write in the name of the child care center in the space provided.

Print the name of each child in your household who attends this child care center.

**Section A:** If anyone in your household receives Food Stamps, Temporary Assistance for Needy Families (TANF) or participates in the Food Distribution Program on Indian Reservations (FDPIR), complete Section A only. Write down the Food Stamp, TANF or FDPIR number (do not use your ACD or DSS child care subsidy number) and sign and date the form and return it to the day care center.

**Foster children:** If your household includes a foster child who is in child care, complete Section A only. Write in the foster child's name and any income that the child receives from social services for his or her personal use. Write in 0 if the foster child does not receive any income. A separate application must be completed for each foster child. The foster parent or an official who represents the child must sign and date the form and then return it to the child care center.

**Section B:** Write in the names of all the people living in your household, even if they do not have any income. Include yourself and all other adults and children in the household, including unrelated people. Do not include the children in child care who are listed at the top of the form.

Enter the amount of income each person received **last month**, before taxes or anything else was taken out. Refer to the Definition of Income and the Definition of Household, above. If any amount last month was more or less than the usual, write in that person's usual income. The signature and Social Security Number of the adult signing the certification is required. If you do not have a Social Security Number, write *none*.

### **Instructions for Centers and Sponsors:**

**The For Sponsor Use Only section is to be completed, signed and dated by child care center or sponsor staff.**

The sponsor/center representative must review the income eligibility application and ensure that it is completed as indicated in the instructions above. Then indicate the following:

**The sponsor agreement number.**

**Total household members** – This item does not have to be completed if the parent completed Section A. Add those indicated in Section B (if completed) to the children enrolled in child care.

**Total Income** – This item does not need to be completed if the parent completed Section A. Indicate the total monthly income as calculated from Section B. If the parent chooses not to disclose income, the application must be categorized as *paid*.

**Free, Reduced or Paid** – Compare the total household income and the total number of household members with the current year's Income Eligibility Guidelines (CACFP-3687) to determine if the household should be categorized as **Free, Reduced or Paid**. Use the appropriate column on the CACFP-3687 to categorize their income. For example, if the parent indicated biweekly income, multiply this amount by 26 to determine yearly income.

Incomplete applications (missing signatures, income information, or Food Stamp, TANF or FDPIR numbers) are categorized in the paid category.

**The income eligibility application is valid until the last day of the month one calendar year from the date of submission.** For example, a form submitted on May 12, 2010 is valid until May 31, 2011.



# PHYSICAL EXAMINATION

(To be filled out by Physician – please note information on reverse side)

The purpose of this health record is to provide the staff with pertinent information, which will help to serve the needs of this child in Day Camps and Afterschool and Youth Center Programs.

## IMMUNIZATION HISTORY – This is a record of dates of basic immunization and most recent booster doses.

DpaP, DTP or TD	Date _____	Date _____	Date _____	Date _____	Date _____
Polio\	Date _____	Date _____	Date _____	Date _____	Date _____
MMR\	Date _____	Date _____	Date _____	Date _____	Date _____
Hemophilus Influenzae type b	Date _____	Date _____	Date _____	Date _____	Date _____
Hepatitis B	Date _____	Date _____	Date _____	Date _____	Date _____
Varicella	Date _____	Date _____	Date _____	Date _____	Date _____
Other _____	_____	_____	_____	Date _____	Date _____

## MEDICAL EXAMINATION – To be filled out by licensed physician

Examination is acceptable when performed no more than 12 months prior to arrival at camp.

Code: S = Satisfactory      X = No Satisfactory (Explain)      0 = Not Examined

General Appearance \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Hgb. Test (Date) \_\_\_\_\_

Urinalysis (Date) \_\_\_\_\_ Posture & Spine \_\_\_\_\_ Throat – Tonsils \_\_\_\_\_

Eyes \_\_\_\_\_ Vision \_\_\_\_\_ w/Glasses \_\_\_\_\_ Extremities \_\_\_\_\_ Heart \_\_\_\_\_

Ears \_\_\_\_\_ Hearing \_\_\_\_\_ Feet \_\_\_\_\_ Lungs \_\_\_\_\_ Skin \_\_\_\_\_

Nose \_\_\_\_\_ Teeth \_\_\_\_\_ Abdomen \_\_\_\_\_ Hernia \_\_\_\_\_

Genitalia \_\_\_\_\_

Neurological Findings \_\_\_\_\_

Describe Abnormal Findings and/or Handicapping Conditions \_\_\_\_\_

Has child ever received products containing horse serum? \_\_\_\_\_

Allergy: (Please specify) \_\_\_\_\_

Recommendations and restrictions while in camp.

Special Diet \_\_\_\_\_

Special Medicine (name it) \_\_\_\_\_

Is parent/guardian sending special medicine? \_\_\_\_\_

Swimming \_\_\_\_\_ Diving \_\_\_\_\_

Activity Restrictions \_\_\_\_\_

General Appraisal: \_\_\_\_\_

I have examined the person herein described, reviewed his/her health history and it is my opinion that he/she is physically able to engage in Day Camp/Year Round Afterschool and Youth Center activities, except as noted above.

M.D.

EXAMINING PHYSICIAN (SIGNATURE)

PHYSICIAN'S NAME (PLEASE PRINT)

Telephone \_\_\_\_\_

Address \_\_\_\_\_

Date of Examination \_\_\_\_\_

ZIP CODE \_\_\_\_\_