



REGISTRATION POLICY

OPENING DAY

BCNY will open for fall afterschool programming on **Monday, September 17.**

SCHOOL HOLIDAY CLOSURES

BCNY is closed when NYC public schools are closed during the school year for regularly scheduled breaks and during unexpected closures due to weather.

ELIGIBLE AGES

New members must be 7 years old to be eligible to register for membership at Abbe Clubhouse and Gerry Clubhouse.

New members must be in 3rd grade and at least 8 years old to be eligible to register for membership at Harriman Clubhouse.

Boys maybe be as old as 21 to register for BCNY programs.

ATTENDANCE POLICY

Registered members ages 12 and under are expected to attend BCNY a minimum of **3 days a week.**

Members who cannot meet these expectations may have their membership reviewed or suspended.

ABBE CLUBHOUSE REGISTRATION DATES

133-01 41st Road Flushing, Queens 11355

Current Members in Good Standing*: **Monday, August 6 - Friday, August 17**

Open registration: **Tuesday, August 28 - Thursday, August 30**

GERRY CLUBHOUSE REGISTRATION DATES

321 East 111th Street, East Harlem, NY, 10029

Current Members in Good Standing*: **Monday, August 6 - Friday, August 17**

Open registration begins **Thursday, September 6**

HARRIMAN CLUBHOUSE REGISTRATION DATES

287 East 10th Street, Lower East Side, NY, 10009

Current Members in Good Standing*: **Monday, August 6 - Friday, August 17**

Open registration begins **Thursday, September 6**

*Current Members in Good Standing: Members who met BCNY's attendance policy during the 2017-2018 Program Year and Summer 2018 Cycle.

For registrar office hours please visit the website: www.bcnny.org/registration

If you are unsure of your registration eligibility, please contact your clubhouse director or registrar for assistance.

WAITLIST

Please note that space is limited. Members will be registered on a first-come, first-served basis. Those members who cannot be immediately registered due to space restrictions will be placed on a waitlist.

Please check the website for registration updates: **www.bcnny.org/registration**

MEMBER REGISTRATION FORM

CLUBHOUSE AFFILIATION

Please choose one. If you need assistance selecting a clubhouse, please call 212.677.1102.

Abbe Clubhouse
133-01 41st Road
Flushing, NY 11355
718.886.7803

Gerry Clubhouse
321 East 111th Street
New York, NY 10029
212.534.2923

Harriman Clubhouse
287 East 10th Street
New York, NY 10009
212.533.2554

\$5 MEMBERSHIP FEE

MEMBER INFORMATION

Age: _____

Grade (as of September 2018): _____

If returning, how many years has he been a member, not including THIS year? _____

If new, how did you hear about BCNY?

School Other parent Other member Internet search Other _____

T-SHIRT SIZE: Youth S Youth M Youth L Youth XL
 Adult S Adult M Adult L Adult XL

REQUIRED REGISTRATION DOCUMENTS

All **FOUR** must be submitted along with this form to complete your registration

- Birth Certificate/Passport (a photocopy is acceptable)
- Updated Immunization Records **OR**
New York Dept. of Education "Medical Request for Immunization Exemption" Form
- CACFP Food Form
- Physical Examination Form (signed, dated, and stamped) **OR**
Prior physical dated no more than two years ago

Please note: **Report cards will be due for all members at the end of November**

**PLEASE RETURN THIS FORM AND REGISTRATION DOCUMENTS
TO THE CLUBHOUSE REGISTRAR**

OFFICE USE ONLY

Explorer: Age 7-9 (2nd - 4th grade) **Junior:** Age 10-12 (5th - 7th grade) **Teen:** Age 13-21 (8th grade & up)

MEMBER INFORMATION				
First Name:		Last Name:		Nickname:
Address :				
STREET	APT#	CITY	STATE	ZIP CODE
Birthday:		Age:		
Race <input type="checkbox"/> Black/African-American <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino		Primary Language (if not English): <input type="checkbox"/> Cantonese <input type="checkbox"/> Creole <input type="checkbox"/> French <input type="checkbox"/> Mandarin <input type="checkbox"/> Spanish <input type="checkbox"/> Other : _____
EDUCATION				
Type of school:		Name of School:		
<input type="checkbox"/> Public <input type="checkbox"/> Charter <input type="checkbox"/> Private <input type="checkbox"/> Parochial <input type="checkbox"/> Home-schooling		Teacher:		
		I.E.P.? <input type="checkbox"/> Yes <input type="checkbox"/> No		
PRIMARY PARENT/GUARDIAN INFORMATION				
First Name:		Last Name:		
Address :				
STREET	APT#	CITY	STATE	ZIP CODE
Home Phone:	Cell Phone:	Work Phone:		
Email Address:				
Employment:		Employment:		
<input type="checkbox"/> One paid full-time job <input type="checkbox"/> More than one paid part-time job		<input type="checkbox"/> One paid part-time job <input type="checkbox"/> No paid job		
Education:		Education:		
<input type="checkbox"/> Some high school/no diploma <input type="checkbox"/> Advanced degree		<input type="checkbox"/> High school diploma/GED <input type="checkbox"/> College degree		
SECONDARY PARENT/GUARDIAN INFORMATION				
First Name:		Last Name:		
Address:				
STREET	APT#	CITY	STATE	ZIP CODE
Home Phone:	Cell Phone:	Work Phone:		
Email Address:				
Employment:		Employment:		
<input type="checkbox"/> One paid full-time job <input type="checkbox"/> More than one paid part-time job		<input type="checkbox"/> One paid part-time job <input type="checkbox"/> No paid job		
Education:		Education:		
<input type="checkbox"/> Some high school/no diploma <input type="checkbox"/> Advanced degree		<input type="checkbox"/> High school diploma/GED <input type="checkbox"/> College degree		
EMERGENCY CONTACTS				
Name:		Relationship:		
Address:				
STREET	APT#	CITY	STATE	ZIP CODE
Phone:	Alt. Phone:			
Name:		Relationship:		
Address:				
STREET	APT#	CITY	STATE	ZIP CODE
Phone:	Alt. Phone:			

PERSON(S) AUTHORIZED TO PICK UP MEMBER FROM CLUBHOUSE

Name/Phone #: _____

Name/Phone #: _____

HEALTH INFORMATION

Doctor: _____ **Preferred Hospital:** _____

Insurance Company: _____ **Insurance Policy Number:** _____

Allergies/Medical Conditions: _____

Has your son seen a Mental Health professional in the past? Yes No
(school social worker, mental health counselor, psychologist, psychiatrist)
If yes, please explain: _____

HOUSEHOLD INFORMATION
Note: This information will remain completely confidential.

Please check your Family Income	Please check your Family Setting	Household Size
<input type="checkbox"/> Less than \$10,000 <input type="checkbox"/> \$10,000 - \$14,999 <input type="checkbox"/> \$15,000 - \$24,999 <input type="checkbox"/> \$25,000 - \$34,999 <input type="checkbox"/> \$35,000 - \$49,999 <input type="checkbox"/> \$50,000 - \$74,999 <input type="checkbox"/> \$75,000 - \$99,999 <input type="checkbox"/> \$100,000 or more	<input type="checkbox"/> Single Parent: Female <input type="checkbox"/> Single Parent: Male <input type="checkbox"/> Two Parents: Unmarried <input type="checkbox"/> Two Parents: Married <input type="checkbox"/> Grandparent(s) as guardian <input type="checkbox"/> Foster Home <input type="checkbox"/> Other Guardian: _____	Family Size: _____ # of Adults: _____ # of Children: _____

PARENT CONSENT (Required for members under 18)

I have read the completed application; I understand the rules of The Boys' Club of New York [BCNY] and I request that the proposed member be admitted. 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 BCNY activities. I understand that BCNY will not administer any medication to members.

I hereby give my permission for photographs and videos of him to be used in BCNY promotional materials and website, and in outside exhibitions, newspaper articles, TV features, online videos, or publications approved by BCNY. I additionally permit his artwork to be used by BCNY for sale or presentation to BCNY board members, supporters, or guests of any kind without compensation. If he attends boarding school, I give my permission for his registration to remain active until graduation. I also give permission for him to participate in BCNY surveys. I understand that BCNY reserves the right to place him on an alternate or abridged schedule if it is deemed appropriate.

Additionally, I do hereby give consent to BCNY's Program staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.

Parent/Guardian
Signature: _____ Date: _____

BCNY OFFICE USE ONLY

New Renewal Explorer Junior Teen

Registration Date: _____ ID# _____

Birth Certificate/Passport/State ID Immunization Medical Release
 Physical | Date of Exam _____ Food Form Report Card

Parent Survey

Please complete the following short survey about your experiences at BCNY. Results will be reviewed anonymously to help us improve our programs and services.

The Boys' Club supports my son (check all that apply):

- Socially Emotionally Academically
- Artistically With Sports N/A
- Other: _____

I get information about BCNY events from (check all that apply):

- BCNY Website Email Phone/Text
- Staff Other Parents Other: _____

In an average week, my son accesses the following (check all that apply):

- Aquatics Programs Education Programs Game Room/Core Programs
- Music Lessons Art Programs Physical Education Programs
- Other: _____

Why do you bring your son to the Boys' Club?

Please provide any additional comments you have below

Thank You!!!

HEALTH RECORD FOR CHILDREN IN DAY CAMPS & AFTERSCHOOL & YOUTH CENTERS

(This side to be filled in by parent before presentation to physician)

Member's Last Name: _____ First Name: _____

Birthdate (mm/dd/yyyy): ____/____/____

Home Address: _____ Phone: _____

Parent or Guardian: _____ Phone: _____

Place of Employment: Primary Parent/Guardian: _____ Phone: _____

Place of Employment: Secondary Parent/Guardian: _____ Phone: _____

In case of emergency, notify: _____ Phone: _____

If Parent/Guardian is not available in an emergency, notify:

1. _____ Phone: _____

2. _____ Phone: _____

Important: Has this member been exposed to any communicable disease during the three weeks prior to BCNY attendance?

No Yes: Type of exposure: _____

Medical Health History (Check appropriate box and give approximate dates)

Illnesses/Conditions

Ear Infections _____

Rheumatic Fever _____

Seizures _____

Diabetes _____

Asthma _____

Other _____

Allergies

Hay Fever _____

Ivy Poisoning, etc. _____

Insect Stings _____

Penicillin _____

Food _____

Other _____

Diseases

Chicken Pox _____

Measles _____

German Measles _____

Mumps _____

Other Contagious

Illnesses _____

Operations or Serious Injuries (Dates) _____

Hospitalization (Dates) _____

Chronic or Recurring Illness _____

Any specific activities to be encouraged? _____

Conditions that require activity to be restricted? _____

Permission for all program activities unless otherwise noted by Dr. _____

Appliance worn (glasses, contacts, etc.) _____

Medication taken (including medication for mental health conditions) _____

Suggestion from Parent/Guardian _____

Mental Health History

Note: For BCNY to best serve your son, please respond honestly and thoroughly. All information will be kept confidential.

Check any that apply:

Behavioral Emotional Learning ADD/ADHD Other Mental Health Conditions _____

Specific Diagnosis, if known _____

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I do hereby give consent to The Boys' Club of New York staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.

Relationship _____ Signature _____ Date _____ Tel. # _____

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.

DTaP, DTP, DT, Td	Date _____	Date _____	Date _____	Date _____	Date _____
Polio	Date _____	Date _____	Date _____	Date _____	Date _____
MMR	Date _____	Date _____	Date _____		
Hemophilus Influenzae type b (Hib)	Date _____	Date _____	Date _____	Date _____	Date _____
Hepatitis B	Date _____	Date _____	Date _____	Date _____	
Varicella	Date _____	Date _____			
Pneumococcal Conjugate (PCV)	Date _____	Date _____	Date _____	Date _____	Date _____
Other _____	Date _____	Other _____	Date _____	Other _____	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 = Not Satisfactory (Explain) 0 = Not Examined

General Appearance _____

Genitalia _____

Height _____ Weight _____ Blood Pressure _____ Posture & Spine _____ Throat - Tonsils _____

Nose _____ Teeth _____ Abdomen _____ Hernia _____ Feet _____ Lungs _____ Skin _____

Hgb. Test (Date) _____ Urinalysis (Date) _____

Eyes _____ Vision _____ w/Glasses _____ Extremities _____ Heart _____

Ears _____ Hearing _____

Neurological Findings _____

Describe Abnormal Findings and/or Handicapping Conditions _____

Allergy: *(Please specify)* _____

Recommendations and restrictions while in camp:

*applies only to Gardiner School

Special Diet* _____

Special Medicine* (dose, route of administration, when should it be administered) _____

Is parent/guardian sending special medicine? * _____

Activity Restrictions _____

Swimming _____ Diving _____

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 _____

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) OR
4. If any of the children enrolled in this child care center are foster children

Complete SECTION B if no one in your household receives Food Stamps, TANF, FDPIR or if none of the children enrolled in the child care center is a foster child.

SECTION A
Food Stamp Case Number _____
TANF Number _____
FDPIR Number _____
Names of Foster Children _____
<p>An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.</p> <p>I certify that the above information is true. I understand that the center will get Federal funds based on the information I give.</p> <p>Signature: _____</p> <p>Date: _____</p>
FOR SPONSOR USE ONLY
Sponsor Agreement Number _____
Total Household Members _____ (including foster children, if applicable)
Total Income \$ _____
Free _____ Reduced _____ Paid _____
Date Determined ____ / ____ / ____
Signature of Center Staff _____

SECTION B	
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 last month in your household in the column to the right. Gross income includes: earnings from work, pensions, retirement, Social Security, child support, foster child's personal income and any other sources of income.	
Name of Household Members	Monthly Gross Income
1. _____	\$ _____
2. _____	\$ _____
3. _____	\$ _____
4. _____	\$ _____
5. _____	\$ _____
6. _____	\$ _____
<p>An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.</p> <p>I certify that the above information is true and that all income is reported. I understand that the center will get Federal funds based on the information I give.</p> <p>Signature: _____</p> <p>Print Name: _____</p> <p>SS# _____ Date: _____</p>	

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this form. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the form. The Social Security Number is not required when you apply on behalf of a foster child or you list a Food Stamps, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the form does not have a Social Security Number. We will use your information to determine if the center is eligible for free or reduced-price meal reimbursement and for administration and enforcement of the Program.

INSTRUCTIONS FOR COMPLETING DOH-3688

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) unemployment compensation; (7) government civilian employee or military retirement, or pensions or veteran's payments; (8) private pensions or annuities; (9) alimony or child support payments; (10) regular contributions from persons not living in the household; (11) net royalties; (12) military benefits received in cash, such as housing allowance except if you are in the Military Housing Privatization Initiative; and (13) 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.

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 ACS or DSS child care subsidy number). Then 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, write in the names of the foster children.

Section B: Complete this section if you did not complete Section A. Write in your name and the names of all other adults and children living in the household, including unrelated people, even if they do not have any income. 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 last four digits of the Social Security Number of the adult signing the certification is required. If you do not have a Social Security Number, write *none*. The form must be signed by an adult member of the household.

Instructions for Centers and Sponsors:

The For Sponsor Use Only section is to be completed, signed and dated by center or sponsor staff. The sponsor/center representative must review the income eligibility form 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 and the number of foster children, if applicable.

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

The income eligibility form is valid until the last day of the month one calendar year from the date it is signed by the household member. For example, a form signed on May 12, 2011 is valid until May 31, 2012.



Junior Dismissal Permission Slip

Dear Parent/Guardian:

To ensure the safety of your son, The Boys' Club of New York (BCNY), will not permit members in the Junior Department aged 10-12, to travel home on their own unless written consent is provided to BCNY by the parent or guardian and the member is comfortable doing so without assistance from staff.

To grant consent for your son to travel home on his own, you are required to sign and submit the permission slip below, and submit it to the Clubhouse Registrar.

If you should have any questions or concerns, please contact the Clubhouse Director. Thank you.

I, _____, give my son, _____,
Parent/Guardian BCNY Member

permission to travel home without an adult escort upon dismissal from the Clubhouse.

Signature: _____

Date submitted: _____



Teen Required Pick-Up Form

Dear Parent/Guardian:

BCNY Teen members are permitted to leave the Clubhouse unaccompanied at the end of the day, so long as they scan out in the lobby.

If you require that your Teen be picked up by an authorized adult, please indicate so below.

If your son's traveling arrangements should change, you must notify Clubhouse staff immediately.

Please sign and detach the bottom portion to confirm your request. Completed forms must be submitted the Clubhouse Registrar.

If you have any questions or concerns, please contact your Teen Director.

I, _____, require that my son, _____,
Parent/Guardian BCNY Member

be picked up by an authorized adult. He is not permitted to travel home alone.

Signature: _____

Date submitted: _____