

Girls Incorporated of Washington County

626 Washington Avenue * Hagerstown, MD 21740 * 301-733-5430

2011 - 2012 MEMBERSHIP FORM

Date of Registration _____ Home Phone # (_____) _____

Name _____ Date of Birth _____

Home Address _____
Street City State Zip

School _____ Grade _____ Age _____

Mother's Name _____ Work Phone (_____) _____

Mother's Employer _____

Mother's email: _____ Cell Phone # (_____) _____

Father's Name _____ Work Phone (_____) _____

Father's Employer _____

Father's email: _____ Cell Phone # (_____) _____

Name of Legal Guardian and Telephone # (*Only if different from parents listed above*) _____

I give my permission for my daughter's photo to be used in various Girls Inc. publications

Parent/Guardian Signature _____ Date _____

I give my permission for my daughter to attend any Girls Inc. field trip that may occur during the afternoon hours until 5:30 pm, throughout the school year. If any field trip is expected to extend past 5:30 pm, a special permission slip will be sent home to be signed.

Parent/Guardian Signature _____ Date _____

PLEASE CHECK ONE FROM EACH CATEGORY BELOW

This information is requested by our National Organization for statistical purposes only

Racial/ethnic profile

_____ Asian Amer/Pacific Islander
_____ Black/African American
_____ Hispanic American/Latina
_____ Native Am/American Indian
_____ White/European American
_____ Multiracial/multiple heritage
_____ Other _____

Family Configuration

_____ Living with two parents
_____ Living with mother only
_____ Living with father only
_____ Living with 1 parent at a time
(joint custody)
_____ Living with neither parent

Yearly Household Income

_____ Below \$10,000
_____ \$10,000 to \$15,000
_____ \$15,000 to \$20,000
_____ \$20,000 to \$25,000
_____ Over \$25,000

Girls With Disabilities

_____ Learning disabilities
_____ Emotional disabilities
_____ Visual impairments
_____ Hidden health disabilities
_____ Multiple disabilities
_____ Developmental disabilities
_____ Mobility impairments
_____ Hearing impairments
_____ Other physical disabilities
_____ Other disabilities
List Other _____

Does your household qualify for the free or reduced lunch program? Yes _____ No _____

Is anyone in your family in the military? If yes, who _____

_____ **PLEASE LIST THE TOTAL NUMBER OF CHILDREN (INCLUDING GIRLS INC MEMBER) UNDER THE AGE OF 18 LIVING IN THE HOME**

2011 - 2012 HEALTH HISTORY FORM

Name _____ Birthdate _____ Age _____
Last First Initial

HomeAddress _____ Phone (____) _____
Street City State Zip

Emergency Telephone # _____

Mother's Name _____ Cell Phone # _____

Emergency Telephone # _____

Father's Name _____ Cell Phone # _____

Name of Family Physician _____ Phone (____) _____

Name of Family Dentist _____ Phone (____) _____

Date of last physical examination _____ Last tetanus shot _____

List any physical limitations _____

(Check all that your child has ever had)

Health History

Diseases

Allergies

Other Illness (please explain)

____ Frequent Ear Infections
____ Convulsions
____ Diabetes
____ Bleeding/Clotting Disorders
____ Hypertension
____ Mononucleosis
____ Psychiatric Treatment
____ Heart Defect/Disease

____ Chicken Pox
____ German Measles
____ Measles
____ Mumps

____ Hay Fever
____ Insect Stings
____ Poison Ivy, etc.
____ Penicillin
____ Asthma
____ Other Drugs (list below)

____ Behavioral
____ Psychiatric
____ Other(list below)

Has your child received all immunizations required by the State of Maryland? _____ Yes _____ No

If no please state reason. (medical, religious, etc.) Show of proof is required. _____

List any regular medication _____

Reason for taking this medication _____

Do you carry family medical/hospital insurance? _____ Yes _____ No

If so, indicate: Carrier _____ Group or Policy # _____

THE AREA BELOW MUST BE COMPLETED FOR YOUR CHILD TO ATTEND

***PLEASE LIST 2 EMERGENCY CONTACTS OTHER THAN PARENT/GUARDIAN
PARENTS WILL BE NOTIFIED FIRST IN CASE OF AN EMERGENCY***

Emergency Contact _____ Phone(____) _____

2nd Emergency Contact _____ Phone(____) _____

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities except as noted.
Authorization for Treatment: I hereby give permission to the medical personnel selected by the director to order X-rays, routine tests, treatment, and necessary transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the director to secure and administer treatment, including hospitalization, for my child as named above. The completed forms may be photocopied for trips.

Signature of parent or guardian _____ Date _____

Witness _____