Girls Incorporated® of Winter Haven

P.O. Box 7285 - 2400 Havendale Blvd.
Winter Haven, FL 33883
Phone: 863-967-2864 or 863-967-2874
Email: lydia@girlsincwinterhaven.org

Registration Form

Date: _____

Child's Name: _____ School: _____
Date of Birth: _____ Age: ____ Grade: ____ T-shirt size: _____

Child's Name: _____ School: _____
Date of Birth: _____ Age: ____ Grade: ____ T-shirt size: _____

Child's Name: _____ School: _____
Date of Birth: _____ Age: ____ Grade: ____ T-shirt size: _____

Parent/Guardian Name: _____ Home Phone: _____
Mother Cell: _____ Dad Cell: _____ Email: _____
Home Address: _____ City: _____ Zip: _____
Mailing Address: _____ City: _____ Zip: _____

Custodial parent/guardian: _____ Child resides with: _____
If there is an unusual custody situation (parent forbidden contact with child, custody dispute, foster care, guardianship, etc.) we must retain a copy of the court order or custody papers.

Include both parents even if one is not in the household
Current Employment:
Mother Employer: _____ Dept: _____ Work Phone: _____

Father Employer: _____ Dept: _____ Work Phone: _____

Household Information: Use the space below to list the names and ages of ALL the members of the household. (Include extended family and significant other relationships).

Total number in household: _____

Name	Last 4 Social Security #	Age	Relationship

Security Release/Emergency Contact Information:

Girls Incorporated releases children to authorized adults only! Please list the authorized people to pick up the above named child from Girls Incorporated of Winter Haven. Each person must be 18 years or older and will be the only ones permitted to pick up this child. In the event it becomes necessary to have an additional person added it is the responsibility of the parent/guardian to notify Girls Incorporated staff and provide authorization in writing on this form. It is further understood that each child is required to be signed out at the end of each day by the person picking her up. In the event of an emergency and the parent/guardian cannot be contacted the following persons are authorized to pick up the above named child. An emergency is defined as an illness, injury, severe discipline situation, or being late to pick up child. Each parent is required to provide three contacts with current working phone numbers (the information will be verified by a Girls Incorporated staff member).

Name	Relationship	Home Phone Number	Work Phone Number

Permission Slip:

My child/children, _____ has my permission to ride Girls Incorporated vehicles when leaving Girls Incorporated premises. My child/children, also has my permission to participate in activities sponsored by Girls Incorporated. I understand completely that reasonable measures will be taken to safeguard my child's safety. Both my child/children and I agree not to hold Girls Incorporated of Winter Haven of the staff members responsible for injuries or accidents. I authorize Girls Incorporated staff to administer first aid.

STATE OF FLORIDA
COUNTY OF POLK
(This notary seal applies to all information stated on these forms).

Sworn to (or affirmed) and subscribed before me this ____ day of _____, _____ by

Parent/guardian name (print): _____

Parent/guardian signature: _____

NOTARY PUBLIC _____ **STAMP**

Notary Public name (print): _____

____ personally known to me ____ Produced identification: _____

Girls Incorporated of Winter Haven is a non-profit, United Way agency. Periodically it becomes necessary to have access to information pertaining to the people we serve. This form will assist us in obtaining information that has been required by United Way, our national organization, and other funding sources. All questions MUST BE answered.

Has your child/children experienced any of the following?

	Yes	No		Yes	No		Yes	No
Allergies			Asthma			Seizures		
Severe Scoliosis			Hearing			Visual		
High Blood Pressure			Heart			Sickle Cell		
Cerebral Palsy			Stomach			Headaches		
Muscular Dystrophy			Diabetes					
Bladder								

If so, should activities be limited, please explain: _____
_____

Has your child ever had any of the following problems?

	Yes	No		Yes	No
Learning Disabilities			Attention Deficit Disorder (ADD)		
Developmental Delay			Attention Deficit/Hyperactivity Disorder (ADHD)		
Emotional Difficulty			Oppositional Defiant Disorder (ODD)		
Limited Mobility					
Other Diagnosed Concerns:					

Please list any additional health concerns, surgical procedures, or severe injuries that may affect your child/children's physical ability or stamina: _____
_____

Family Information:

Child resides with both natural parents ___
Child resides with mother only ___
Child resides with father only ___
Child resides with one natural and
One step parent/live in/significant other ___
Child resides with other ___

City where parent/guardian works _____
City where parent/guardian works _____
Housing: Rent ___ Own ___ Live with others _____
who? _____ Temporary? _____
Did you attend Girls Inc. as a child _____
who? _____

Do you (parent) have any friends of relatives who attended Girls Inc. as a child? If so, list name:
_____

Racial/Ethnic Information:

Asian American ___ Black American ___ Hispanic/Latino ___
American Indian ___ White/European ___ Haitian/Caribbean ___ Other ___

Annual Household Income:

Below $4,999	___	$20,000 – 24,999	___	$40,000 – 44,999	___
$5,000 – 9,999	___	$25,000 – 29,999	___	$45,000 – 49,999	___
$10,000 – 14,999	___	$30,000 – 34,999	___	$50,000 - Above	___
$15,000 – 19,999	___	$35,999 – 39,999	___		

Source of Income / Monthly Gross Estimate

Employment	$ _____	Social Security	$ _____	Disability	$ _____
Alimony	$ _____	Unemployment	$ _____		
Child Support	$ _____	Other Income	$ _____		

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PERMISSION FOR MEDICAL TREATMENT

I, the undersigned, being the parent, legal next-of-kin, or legal guardian of:

_____
Child's Name

Hereby authorize any necessary treatment for the above named child while participating in any of the activities of Girls Incorporated of Winter Haven in and out of Polk County Florida. I also guarantee payment of all charges incurred during this medical treatment (Physician, hospital, x-ray, lab, medication, ambulance, etc.)

MEDICAL INFORMATION

1. List all allergies to foods, medications, etc. _____
2. List medical history (include illnesses, surgeries, etc.) _____
   _____
3. List medications taken regularly (include dosage and schedule) _____
   _____
   _____
   NOTE: an additional medical form must be completed for administering medications.

FAMILY PHYSICIAN: _____
Office address: _____ Phone number _____

INSURANCE INFORMATION Please provide a copy of child's insurance card
Insured's name: _____ Employer: _____
Medical insurance company: _____ Group/Policy # _____

STATE OF FLORIDA
COUNTY OF POLK
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Parent/guardian name (print): _____

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