GIRLS INCORPORATED of Greater Lowell
220 Worthen Street, Lowell, MA 01852
Voice: 978 458 6529 Fax: 978 458 4837
information@girlsinclowell.org
www.girlsinclowell.org

MEMBERSHIP APPLICATION

(Please Print)

Member's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Current Age:_____

I attend the _____ school Grade:_____

Child's Identifying Information

*****Please provide a picture of your child if available.

Eye Color: _____ Hair Color: _____ Sex: _____

Height: _____ Weight: _____Race/Ethnicity: _____

Identifying Marks: _____

Parent/ Guardian Information

Parent/Guardian:_____

Address (If different than above): _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Hours at Work: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Parent/Guardian:_____

Address (If different than above): _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Hours at Work: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Office use only

Date Rec.: _____ Program: ASP Teen Summer Member Type: PPC VDC

Transport: Y N Trax db date/ init: _____ Agency db date/ init: _____

Required? Y N

Emergency Contacts

If the parent/guardian cannot be reached in an emergency,
Girls Incorporated is authorized to contact the following persons:

Name: _____ Relationship: _____

Address: _____ Phone: _____

Name: _____ Relationship: _____

Address: _____ Phone: _____

Name: _____ Relationship: _____

Address: _____ Phone: _____

Blanket Permission / Authorization

My child has permission to take part in the activities of Girls Incorporated of Greater Lowell (Girls Inc.), including, but not limited to, gymnastics, sports, swimming, art, crafts, etc., **unless such activity is limited by pre-identified health considerations.**

Permission is given for my child to participate in field trips outside of the facilities of Girls Inc., whether transportation is provided by public or private vehicles, owned or leased by Girls Inc.

Permission is given for my daughter to appear on Girls Inc.'s print outlets. I approve of the use, publication, exhibition, distribution and disposal of materials my child made while at or participating in an activity of Girls Inc. This includes:

● Photographs ● Films ● Print Ads ● Video Tapes ● Voice Recordings ● Electronic Representations

*Any photographs, films, videotapes, voice recordings, etc. are the sole property of Girls Inc.

In the event of an emergency, I hereby permit and authorize Girls Inc. to carry out any measure deemed necessary for my child's well being, including administering first aid; and securing appropriate medical treatment at the expense of the undersigned. Further I agree to release all employees, volunteers and agents of Girls Inc. from any and all liability or claims arising out of any such accident or emergency.

I have read and received a copy of the rules and late fee policies of Girls Inc. and agree to abide by the terms, conditions and payment schedule(s).

Parent/Guardian Signature: _____ Date: _____

Member's Pledge

As a member of Girls Incorporated, I will be considerate of the rights of fellow members, and practice fair play, honesty and good sportsmanship in all Girls Inc. activities. I understand that my right to membership depends upon respect for Girls Inc., its equipment, rules, membership, and staff.

Member's Signature: _____ Date: _____

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HEALTH INFORMATION FORM

(Please Print)

Member's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Current Age:_____

Parent/Guardian: _____

Work Phone: _____ Cell Phone: _____

Parent/Guardian: _____

Work Phone: _____ Cell Phone: _____

Name of Physician/Clinic: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Is there documentation of a physical exam, immunization record, and lead screening on file at your child's school? **YES**☐ **NO**☐

Date of Last Tetanus Shot: _____

By checking this box ☐ I have chosen to **DISCLUDE** my child from the EEC mandated oral hygiene program.

Does your child have allergies to medication and/or other substances? **YES**☐ **NO**☐

If **YES** please list:_____

If your child has a medical condition and/ or if medication(s) is to be dispensed at Girls Inc., please complete the Individual Health Care Plan Form and Medication Consent Form on the reverse side of this form.

In the event of an emergency, I hereby authorize Girls Incorporated of Greater Lowell to administer first aid to and secure any necessary medical treatment at the nearest:

Hospital/Medical Facility for my child: _____

Parent/Guardian Signature: _____ Date: _____

To be completed by a Licensed Health Care Practitioner and the Parent/ Guardian

Individual Health Care Plan Form & MEDICATION CONSENT FORM

Plan must be renewed annually or when the child's condition changes

Name of Child: Date:
Name of medical condition:
Description/ symptom(s) of medical condition:
Will the child require medical treatment while at the program (circle): **YES** **NO** List all:
Medication(s): Date prescribed:
When will medication be administered at Girls Inc.: Time(s) dose due: Day(s) dose due (circle): Su **M T W Th F** Sa
Directions for storage:
List any potential side effects of treatment/ medication:
Potential consequences if treatment/ medication is not administered: Doctor When should Health Care Practitioner be called?
Name/ address/ phone of prescribing physician:
Name of staff that reviewed IHCP & Medication Consent Form with Parent/ Guardian:

Name of Licensed Health Care Practitioner (please print):_____ License #:_____

Licensed Health Care Practitioner Signature:_____ Date:_____

Please Note: an original prescription from the prescribing doctor and an original medication bottle from the pharmacy will need to be submitted to the Agency by the members' start date in the program.

I, _____ (Parent/Guardian), give permission to authorized staff members of Girls Incorporated of Greater Lowell to administer medication to my child as indicated above.

Parent/Guardian Consent Signature: _____ Date: _____

Staff person accepting medication: _____ Date: _____

For Older Children Only (9+ years of age)

With written consent and authorization of a licensed health care practitioner, this Individual Health Care Plan permits older school age children to carry their own inhaler and/ or epinephrine auto-injector and use them as needed without the direct supervision of a Girls Inc. staff.

The Girls Inc. staff is aware of the contents and requirements of the child's Individual Health Care Plan specifying how the inhaler or epinephrine auto-injector will be kept secure from access by other children in the program. Whenever an Individual Health Care Plan provides for a child to carry his or her own medication, the licensee must maintain on site a back-up supply of the medication for use as needed.

Age of child: _____ Date of birth: _____ Back-up of medication received (circle)? **YES** **NO**

Parent/ Guardian Signature: _____ Date: _____

Program Coordinator Signature: _____ Date: _____

For Office use only

Plan is maintained by**:**

Program Coordinator's Office ☐ Other ☐ : _____

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TRANSPORTATION PLAN

(Please Print)

Member's Name: _____

MY CHILD WILL **ARRIVE** AT THE PROGRAM BY:

_____ Unsupervised Walk

_____ Supervised Walk (With whom? _____)

_____ School Bus Drop Off

_____ GIRLS INC. VAN (See other side)

_____ Parent Drop Off

_____ Other (Describe: _____)

MY CHILD WILL **DEPART** FROM THE PROGRAM BY:

_____ Parent/ Guardian Pick Up

_____ Unsupervised Walk

_____ Supervised Walk (With whom? _____)

_____ Other (Describe: _____)

I give my permission for my child to be released from the program at the end of the day as indicated above and/or I give my permission to the following people to receive my child at the end of the day.
If no one is authorized, please indicate below by writing "NO ONE"

1. Name _____ Relationship _____

   Address _____ Phone ( ) _____

2. Name _____ Relationship _____

   Address _____ Phone ( ) _____

3. Name _____ Relationship _____

   Address _____ Phone ( ) _____

4. Name _____ Relationship _____

   Address _____ Phone ( ) _____

THE ABOVE TRANSPORTATION PLAN SHALL BE IMPLEMENTED AS OF THE DATE OF SIGNATURE. ANY CHAGES MUST BE REQUESTED IN WRITING. A COPY OF THIS PLAN SHALL BE MAINTAINED IN THE MEMBER'S FILE. THIS TRANSPORTATION PLAN IS VALID UNTIL THE END OF THE PROGRAM YEAR FROM THE DATE OF SIGNATURE.

PARENT / GUARDIAN SIGNATURE _____DATE _____

AFTER SCHOOL PROGRAM

TRANSPORTATION CONTRACT

I, _____, give my permission for **GIRLS INCORPORATED** of Greater Lowell to transport my child, _____, from the _____ School, grade _____, beginning _____, and thereafter for each month of the remaining school year, to its facility after school. I understand that pick-ups will only be provided on scheduled full days of school for the majority of Lowell Public Schools.

The transportation fee is **$** _____ per month. All fees for transportation are **nonrefundable.** Payment of transportation fees must be made in advance and are due before the 1st day of the month of service.

I understand that when my child is transported from her school to the facility, she is picked up within a reasonable window of time following formal dismissal and that this timeframe is contingent on many factors, such as traffic, conflicting or simultaneous school releases, maneuvering school bus usage route and accessibility to school property.

Should my child be absent from school or not require transportation on a given day (which includes days on which my child's school schedule differs from the majority of Lowell Public schools,) I agree to notify GIRLS INCORPORATED of Greater Lowell by no later than noon on that day. I understand that failure to comply with this stipulation may result in the cancellation of this TRANSPORTATION CONTRACT.

I agree to hold **GIRLS INCORPORATED** of Greater Lowell, its staff, volunteers and Board of Directors harmless in the event of any loss of personal property or injury incurred while being transported in a **GIRLS INCORPORATED** of Greater Lowell vehicle.

This service may be terminated by either party with one week's advance notice.

_____ _____

Signature of Parent/Guardian DATE

_____ _____

for GIRLS INCORPORATED of Greater Lowell DATE

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MEMBER / HOUSEHOLD SELF-DECLARATION OF INCOME

INFORMATION PROVIDED ON THIS FORM IS CONFIDENTIAL

MEMBER: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____ **PHONE NO.:** _____

Federal regulations require we obtain this information to document that assistance is being provided to low and moderate-income households. The Participant/Guardian should complete this form indicating all persons residing within their household, regardless of whether or not they are related. The Grantee should retain this form for monthly reporting requirements as well as for on-site monitoring visits.

SECTION 1: YOUR FAMILY MAKE UP: MEMBER LIVES WITH?

A. ☐ **MOTHER ONLY** **B.** ☐ **BOTH PARENTS** **C.** ☐ **FATHER ONLY**
D. ☐ **LEGAL GUARDIAN** **E.** ☐ **OTHER** _____

NUMBER OF CHILDREN IN FAMILY _____ LIVING AT HOME: _____ AGES: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

SECTION 2: ETHNIC & CULTURAL BACKGROUND:

Is your child? ☐ **Hispanic or Latino** ☐ **Not Hispanic or Latino**

What is your family's spoken language in the home? _____

YOUR CHILD'S RACIAL BACKGROUND (PLEASE SELECT ONLY ONE)

☐ White
☐ Black/African American
☐ Asian
☐ American Indian/Alaska Native
☐ Native Hawaiian/Other Pacific Islander
☐ American Indian/Alaskan Native ***and*** White
☐ Asian ***and*** White
☐ Black/African American ***and*** White
☐ American Indian/Alaskan Native ***and*** Black/African American
☐ Other Multi-Racial: _____

SECTION 3. HOUSEHOLD INFORMATION

1) ***Circle the number of family and non-family members living in your household below.***
2) ***Circle the corresponding income level (FY2019-20 Median Family Income)*** ***Note: Does not need to be on same row as number of household size ~ should be accurate yearly household income. (Effective June 28, 2019)***

Household Size		#1 (0% - 30%)	#2 (31% - 50%)	#3 (51% - 80%)	#4 (81% and above)
1		$0-$22,650	$22,651-$37,700	$37,701-$52,850	$52,850+
2		$0-$25,850	$25,851-$43,050	$43,051-$60,400	$60,401+
3		$0-$29,100	$29,101-$48,450	$48,451-$67,950	$67,951+
4		$0-$32,300	$32,301-$53,800	$53,801-$75,500	$75,501+
5		$0-$34,900	$34,901-$58,150	$58,151-$81,550	$81,551+
6		$0-$37,500	$37,501-$62,450	$62,451-$87,600	$87,601+
7		$0-$40,100	$40,101-$66,750	$66,751-$93,650	$93,651+
8		$0-$42,650	$42,651-$71,050	$71,051-$99,700	$99,701+

I certify the above information is true and correct to the best of my knowledge.

Participant/Guardian: _____ **Date:** _____

(Original signature is required)

SECTION 4: HOW DID YOU HEAR ABOUT GIRLS INCORPORATED of Greater Lowell?

A. ☐ WORD OF MOUTH **B**. ☐ PAMPHLET **C.** ☐ SCHOOL **D.** ☐ WEBSITE

E. ☐ OTHER (PLEASE LIST) _____

SECTION 5: FAMILY INCOME WORKSHEET

☐ PLEASE CHECK HERE IF YOU'D LIKE TO BE CONSIDERED FOR THE **BOARD SCHOLARSHIP PROGRAM.** The Board Scholarship Program is donation designated to support children that do not receive supplement Out of School Time support from the Commonwealth of Massachusetts.

THIS SECTION MUST BE COMPLETED TO PARTICIPATE IN THE GIRLS INCORPORATED SHOLARSHIP PROGRAM.

PARENT / GUARDIAN EMPLOYMENT INFORMATION

MOTHER'S NAME: _____ CELL PHONE: ( ) _____

EMPLOYER: _____ WORK PHONE: ( ) _____

JOB ADDRESS: _____ ANNUAL INCOME: $ _____

CITY, STATE, ZIP _____

FATHER'S NAME: _____ CELL PHONE: ( ) _____

EMPLOYER: _____ WORK PHONE: ( ) _____

JOB ADDRESS: _____ ANNUAL NCOME: $ _____

CITY, STATE, ZIP _____

OTHER SOURCES OF INCOME:

AFDC: $ _____ **UNEMPLOYMENT: $** _____

SOCIAL SECURITY: $ _____ **WORKER'S COMP: $** _____

OTHER (PLEASE LIST) $ _____ **OTHER (PLEASE LIST) $** _____

TOTAL FAMILY INCOME: $ _____ **TOTAL FAMILY SIZE:** _____

(PROOF OF INCOME MUST BE PROVIDED: FOUR (4) WEEKS RECENT PAY STUBS OR PAGE 1 OF YOUR MOST RECENT TAX RETURN OR LETTER OF AWARD.)

THE FINANCIAL INFORMATION PROVIDED BY ME IS TO THE BEST OF MY KNOWLEDGE TRUE AND CORRECT AND I WILL NOTIFY GIRLS INCORPORATED of Greater Lowell OF ANY CHANGES IN MY FINANCIAL SITUATION.

_____ _____

Parent/Guardian Signature **Date**

For Office Use Only:

Date: _____ **Program:** _____ **Rate:** _____ **per:** _____

Date: _____ **Program:** _____ **Rate:** _____ **per:** _____

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GIRLS INC. PROGRAMMING GOALS

(Please Print)

Member's Name: _____

Please fill out the questions below to help us better meet your child's needs and to help your child fully engage in the program.

Check YES or NO for the following questions. If YES, please explain.

1. Does your child have an Individualized Education Plan (IEP)? **YES☐ NO☐**

   If **YES**, what goals are identified on the plan? _____
   _____

2. Outside of the school setting, does your child receive extra help in:

   READING ☐ MATH☐ OTHER☐ (Describe)_____

3. Does your child need homework help?

   YES☐ NO☐

4. Does your child have an identified need for any type of added supports, i.e. one-on-one?

   YES☐ NO☐

   If **YES**, please explain: _____
   _____

5. Has your child been identified with any physical or psychological condition which may restrict her activities or affect her behavior or ability to learn? **YES☐ NO☐**

   If **YES**, please explain: _____

   Current medications: _____

Please check any additional interests your child may have to better help us place her in our programs.

Sports & Fitness☐ Cooking/Nutrition☐ Literacy☐ Science☐ Math☐ Money Management☐

Stress Management☐ Social Skills☐ Arts & Humanities☐ Technology☐ Health Education☐

Career/College Prep☐ Culture☐ Media☐ Leadership & Community Engagement☐