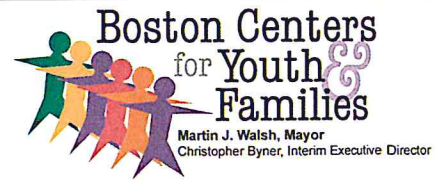


BCYF Blackstone Community Center
50 West Brookline Street
Boston, MA 02118
Telephone 617-635-5162 Fax 617-635-5057



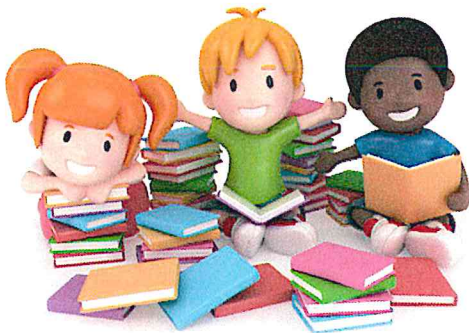
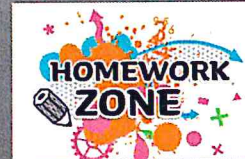
Sign-Up Now

Blackstone Connects

A drop - in after school program

Beginning Tuesday, October 13, 2015

Grades 3 to 7 /Ages: 8-12
Monday through Friday
3:00 pm to 6:30 pm



Applications are now available

Cost: \$20:00 per child per week
Limited Scholarships Available

Tutoring, Arts & Crafts, Swim & Gym, Computers and more...

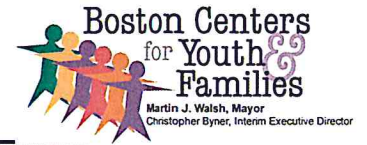
No cash accepted
Please make checks and or money orders payable to the
Blackstone Community Center

For more information contact, Keith Houston and Marco Torres at
617- 635 - 5162.....





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BLACKSTONE CONNECTS
Drop-In Program Registration Packet
School Year / 2015-16

Membership Fee \$ _____ Program Fee \$ _____

(PLEASE PRINT CLEARLY)

Verification Stamp

Participants Name: _____

Age: ___ Date of Birth: ___/___/___ Sex: M F Current Grade: ___ School: _____

Parent /Caregiver Name: _____

Address: _____

City/Neighborhood: _____ State: _____ Zip code: _____

Telephone Information -Please include area codes. Home #: _____

Work#: _____ Cell #: _____ E-Mail: _____

1. Does your child have any medical restrictions or allergies? (If yes please explain) YES NO

2. Is your child currently under a doctor's care? (If yes please explain) YES NO

3. Is your child currently taking any medication (s)? (If yes please explain) YES NO

4. Does your child have any dietary restrictions? (If yes please explain) YES NO

5. What is the language spoken at home? _____

6. Who do we contact other than yourself in case of an emergency?

Name: _____ Relationship: _____

Address: _____ City/Neighborhood: _____

State: _____ Zip code: _____ Telephone Information –please include area codes Home#: _____

Work #: _____ Cell#: _____ E-Mail: _____

Signature of Parent/ Caregiver: _____ Date: _____



Hospital / Clinic Information

7. Name Hospital / Clinic: _____

Address: _____ City / Neighborhood: _____

State: _____ Zip code: _____ Telephone#: _____ E-Mail: _____

Pediatrician Name: _____

Telephone # (if different from above): _____

Name Insurance: _____ Insurance Card#: _____

Parent/Caregiver Signature: _____

8. **Identification Information**

PHOTO OF CHILD

Childs Nick Name _____

**Optional
Optional
Optional
Optional**

Identifying Marks (please be specific) _____

Height _____

Weight _____

Eye Color _____

Skin Color _____

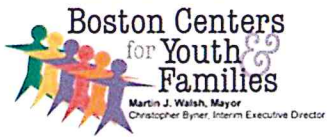
Hair Color _____

Sneaker / Shoe Size _____

Reviewing Staff / Instructor Signature: _____ Date: _____

Title / Position _____

Date Received: _____ Staff Member Entering: _____ ID: _____ Fee Type: _____



Youth Membership Application

The mission of Boston Centers for Youth & Families is to enhance the quality of life for Boston residents by partnering with community center councils, agencies, and businesses to support children, youth, individuals and families through a wide range of comprehensive programs and services according to neighborhood needs.

MEMBER INFORMATION

First Name: _____ Last Name: _____ Female Male

Home Address: _____ Date of Birth: _____
Street Apt. City/Neighborhood Zip Code

Home Phone: _____ Cell Phone: _____ Email: _____

Ethnicity (select all that apply): Asian Black Native American Native Hawaiian White Are you of Hispanic or Latino origin? Yes No

School: _____ Grade: _____

Type of School: Public Charter Private/Parochial Homeschool

Child lives with (select all that apply): Both Parents Mother Only Father Only Aunt/Uncle Sister/Brother Step Parent

Grandparent Foster Parent Guardian Other: _____

Medical Information

Health Insurance Company: _____ Hospital Name: _____

Do you have any medical conditions or allergies? No Yes. If yes, please select type/s and describe below:

Allergies Asthma Physical Restrictions Medications Other: _____

Description: _____

Is there any additional information we should know about this/you? No Yes: _____

Parent/Guardian Contact Information *(These two contacts are authorized to pick-up youth from Boston Centers for Youth & Families Community Centers.)*

Parent/Guardian Name: _____ Parent/Guardian Name: _____

Home Address: _____ Home Address: _____
Street Apt. City/Neighborhood Zip Code

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

Emergency Contact Information *Please specify two people (other than a parent or guardian for youth) who can be contacted in case of emergency.*

(These two contacts are authorized to pick-up youth family members from the Boston Centers for Youth & Families Community Center.)

Primary Contact Name: _____ Secondary Contact Name: _____

Home Address: _____ Home Address: _____
Street Apt. City/Neighborhood Zip Code

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

Consent

I have read and understand the BCYF Code of Conduct and the BCYF Pool Rules and Regulations. I agree that I will act in accordance with the BCYF Code of Conduct and abide by BCYF's Pool Rules and Regulations.

The application is factual and complete to the best of my ability.

I hereby waive and release any and all rights, causes of action, and claims for damages I may have against the City of Boston, Boston Centers for Youth & Families (BCYF), and any and all other associated individuals or organizations, for any and all personal injuries or property damage resulting from my participation in BCYF Programs.

I, the undersigned parent or guardian of [_____], a minor, hereby consent to his/her BCYF membership and waive and release any and all rights, causes of action and claims for damages I may have against the City of Boston, BCYF, and any and all other associated individuals or organizations, arising out of any and all personal injuries or property damage which I may now or hereafter have as the parent or guardian of said minor, and also all rights, causes of action, and claims which said minor has or may acquire resulting from his/her participation in the program.

I give consent for me/my child to be administered first aid and to be treated by an emergency medical technician-paramedic, nurse or physician. Any follow up medical attention may be given at a local hospital and transportation to a Boston hospital is authorized. I give my consent for photographs, audiotapes, and video records of me/my child to be used by BCYF for publicity purposes. I also agree to allow BCYF to use photographs, audiotapes, video records or other work produced by the member for publicity purposes.

I understand that transportation is not provided and it is my responsibility to arrange transportation to and from BCYF Community Centers and programs.

Failure to comply with these rules and expectations can lead to termination of membership.

Signature of Member

Date

Signature of Parent/Guardian *(if member is under 18)*

Date