



(FOR OFFICE USE ONLY)	CLUB: _____	KIDTRAX ID: _____	RECEIPT NUMBER: _____
NEW OR RENEWAL	DATE ENTERED: _____	RECEIVED BY: _____	

Confidentiality Clause: Any information requested is for our records and for the funding our Organization receives. The information you provide will be kept in strict confidence. Your cooperation in providing this information is both necessary and appreciated.

Member Information:

First Name _____	Last Name _____
Date of Birth _____	
School _____	Grade _____

Membership Type:
After-school
Summer
TORP
Gender:
Male
Female
Ethnicity:
African
American/Black
Caucasian/White
Hispanic/Latino
Native American
Asian
Bi-Racial
Other

Head of Household	
First Name _____	Last Name _____
Address _____	
City _____	State _____ Zip _____
Phone Number _____ (home)	_____ (cell) _____ (work)
Employer _____	Occupation _____
Parent/Guardian	
First Name _____	Last Name _____
Address _____	
City _____	State _____ Zip _____
Phone Number _____ (home)	_____ (cell) _____ (work)
Employer _____	Occupation _____

Medical Information: This information helps us better serve your child's needs.
Family Doctor's Name: _____ Doctor's Phone _____
Health Insurance Provider: _____
Medical Problems & Allergies: _____
Medications: _____
Disabilities (physical, mental & behavioral): _____

Check if applicable:
School Lunch
TANF
Food Stamps
General Assistance
SSI
Veterans Assistance
Medicaid
Can Swim

