McGivney Community Center

338 Stillman Street, P. O. Box 5220 : Bridgeport, CT 06610-0220

Evening Membership Application 2008-2009 (18 and over)

FIRST NAME: ______________________________ LAST NAME: ___________________________ SEX: _____

ADDRESS: _________________________________ CITY: __________________ STATE: _____ ZIP: _________

HOME TELEPHONE: ____

AGE: ________ DATE OF BIRTH: __________________ E-Mail Address: _____________________________________

HOW MANY PEOPLE LIVE IN THE HOUSEHOLD WITH YOU (TOTAL ALL ADULTS AND CHILDREN)?__________

ETHNIC ORIGIN: ☐**HISPANIC/LATINO** ☐**NON-LATINO**

PLEASE MARK ALL ETHNIC ORIGINS THAT APPLY:

☐ BLACK/AFRICAN AMERICAN| WHITE | ☐ ASIAN

☐ AMERICAN INDIAN/ALASKAN NATIVE

☐ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER

☐ BLACK/ AFRICAN AMERICAN & WHITE

☐ ASIAN & WHITE

EDUCATION:

HIGH SCHOOL: ______________________________

GRADE: ________ YEAR OF GRADUATION: __________

COLLEGE/ UNIVERSITY: _________________________

YEAR: ___________ MAJOR: ____________________

DEGREE EARNED: YES ☐ / NO ☐

EMPLOYMENT:

☐ FULL TIME ☐ PART TIME ☐ UNEMPLOYED

POSITION: _______________________________

EMPLOYER NAME: _______________________

Please check the appropriate income range for the household:
AFDC: YES ☐ / NO ☐

☐ $0 - $3,999 | ☐ $4,000 - $7,999 | ☐ $8,000 – $11,999 |

☐ $12,000 – $15,999 | ☐ $16,000 - $19,999 | ☐ $20,000 – 23,999

☐ $24,000 – $27,999 | ☐ $28,000 - $31,999 | ☐ $32,000 – $35,999

|☐ $36,000 – $39,999 | ☐ $40,000 - $43,999 | ☐ $44,000 – $47,999

☐ $48,000 – $51,999 | ☐ $52,000 - $55,999 | ☐ $56,000 - $59,999 |

☐ $60,000 – 63,999 ☐ $64,000 – $67,999 | ☐ over $68,000

EMERGENCY CONTACT:

Name. _______________________________

RELATIONSHIP TO YOU:_______________

PHONE # ___________________________

PLEASE READ AGREEMENT ON THE REVERSE SIDE BEFORE SIGNING

SIGNATURE: ____ DATE: ____________________________

Adult Membership Agreement

I hereby certify that I am physically able to participate in all programs offered by the McGivney Community Center, Inc.

In consideration of this application being accepted by the Center, I do hereby waive and release, for myself, my heirs, executors, administrators or representatives, any and all rights or claims for damages or other release that I may have against the McGivney Community Center, Inc. or its authorized agents, for any and all injuries that may be suffered by myself as a result of my participation in any or all of the Center's programs.

I further agree that I shall accept and abide by the direction, instruction and authority of the Center's appointees, staff and coaches. I further agree that I shall respect the rights and privileges of others and abide by the rules and courtesies of fair play and sportsmanship.

I further agree to accept full responsibility for all center equipment or uniforms as may be issued or lent to me and I shall compensate the Center for any loss, destruction or damage to such equipment or uniforms.

I understand that the violation of any terms and provision of this application may result in suspension or expulsion from participation.

I hereby certify that I have read, fully understand and agree to the terms and provision contained in the membership agreement.

As a member of the McGivney Community Center:

I will treat all staff, members with respect.

I will care for all equipment as if it were my own.

I understand that if I am caught swearing, stealing, fighting, disrespecting other members or staff, damaging equipment or property, lying, or involved in any other action that the Center staff deems inappropriate, I can be removed from the center for the day, evening, and depending on the seriousness of the offense, I may be suspended for a period of time.

The information provided is correct as far as I know and I give myself permission to participate in all activities scheduled by the McGivney Community Center staff except as noted by me or the examining physician. I hereby give permission to the physician selected by the McGivney Community Center to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery, for myself. I also understand that I will forfeit my rights to participate if any of the provided information is found to be false.

FOR OFFICE USE ONLY:

PROGRAM(S)	COST	CHECK/ CASH	EMPLOYEE INITIALS	DATE

McGivney Community Center
Emergency Card

Child's Name ____ Birthdate: ________________

Home Address: ____

Mother/Guardian's Name: ____

Work# _______________________ Home#_____________________ Cell/pager __________________

Father/Guardian's Name: ____

Work# _______________________ Home#_____________________ Cell/pager __________________

Emergency Contact Name: ____

Work# _______________________ Home#_____________________ Cell/pager __________________

Address: ____

Physician's Name: _______________________________________ Number:______________________

Medical Conditions: ____

Medications: ____

Allergies (especially to food or drugs) ____

____

Hospital parents/guardians would like child transported to in case of emergency:

____

Insurance provider: ______________________ Policy number: _________________________________

____ _______________________

Signature of parent/guardian Date

COMMUNITY DEVELOPMENT BLOCK GRANT PROGRAM

Household Information Sheet

This information is required in order to determine eligibility for assistance under a federally assisted program. The responses on this form will be used for eligibility decisions and statistical purposes only and will otherwise be held strictly confidential. PLEASE ANSWER ALL QUESTIONS.

Name of Head of Household:		
Street Address (No P.O. Boxes)		
Head of Household's Age:	[ ]Under 62 years	[ ] Over 62 years
Number of persons in household, including head of household:		
Gender of Head of Household:	[ ] Male	[ ] Female
Is Head of Household Handicapped? If yes, please note type of disability:	[ ] Yes	[ ] No
ETHNICITY AND RACE OF HEAD OF HOUSEHOLD: ETHNICITY: [ ] Latino/a [ ] Non-Latino/a	RACE: [ ] Black [ ] White [ ] Asian [ ] Other [ ]Native Hawaiian/Pacific Islander [ ] American Indian/Alaskan Native	

ANNUAL HOUSEHOLD INCOME

Please list gross annual income and source of income for all persons living in the household who are over the age of 16 and not in school.

Source of Income (Employer, Agency, Public Assistance or Individual Who Pays Member of Household)	**Annual Income**

CERTIFICATIONS: I hereby certify that the information on this form is complete and correct to the best of my knowledge.

Signature, Head of Household: ______________________________ Date: ______________