



**United Way of Tri-County  
TOWN OF MILFORD, MASSACHUSETTS  
MILFORD YOUTH CENTER**

24 Pearl St., Milford, MA 01757 (508) 473-1756 Phone  
Membership Form

Participant's Name \_\_\_\_\_ Gender: Male Female

Ethnicity \_\_\_\_\_ Primary Language Spoken \_\_\_\_\_ Secondary Language(s) \_\_\_\_\_

Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Grade \_\_\_\_\_ School \_\_\_\_\_ Valid from September 1, 2012 to September 1, 2013

Physical Address \_\_\_\_\_

City \_\_\_\_\_ State MA Zip \_\_\_\_\_ Resides with \_\_\_\_\_

Parent/Guardian's Name \_\_\_\_\_

PHONE #'S - (H) \_\_\_\_\_ (W) \_\_\_\_\_ (other) \_\_\_\_\_

Email \_\_\_\_\_ Is child part of the free lunch program at school: Yes / No

Knowing that the physical condition of my child is satisfactory to participate at the Milford Youth Center and activities, I hereby give permission for him/her to participate. I understand that my child's name and photo may be used in photographs, videos, literature, web pages, and news releases in local papers and other media outlets. I further accept responsibility for my child in case of injury. I hereby release the Milford Youth Center and its Employees, the towns and their agents, and such other officers and/or volunteers from any liability that may occur to my child, as a result of an accident.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

MEDICAL INFORMATION

On rare occasions, an emergency requiring hospitalization and/or surgery develops. As a general rule, anesthesia may not be administered to or operations performed upon a minor without written permission by his/her parent/guardian. Therefore, in order to prevent a dangerous delay, if an emergency does occur and we are unable to contact the parent or legal guardian, the parent/guardian is asked to sign the release form below.

In the event of injury or illness to me/my son/daughter/, \_\_\_\_\_, born on, \_\_\_\_\_, I hereby authorize Milford Youth Center representative(s) to secure whatever treatment is deemed necessary and, if recommended by an attending physician, the administration of an anesthetic or surgery. We do hereby release and discharge the Milford Youth Center, officers, employees, and agents, from any and all actions or claims for damages suffered by me/us or my/our child, as a result of the permission for any medical care for my/our child during his/her participation in any Milford Youth Center activity, event or trip.

1. Known allergies to food, drugs, insect stings or bites, etc:
  
2. Special medical concerns or conditions that event supervisors should know about, including epilepsy, asthma, diabetes, previous injuries to bones/joints, etc:
  
3. Medications currently being taken (Dose and Frequency):

MEDICAL INFORMATION

Physician's name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_  
 Date of last tetanus shot: \_\_\_\_\_

Milford Youth Center does not purchase insurance for youth participants. Please provide participant insurance.  
 Hospitalization Insurance Company: \_\_\_\_\_  
 Hospitalization Insurance Policy Number: \_\_\_\_\_  
 Company Address: \_\_\_\_\_  
 Area Code and Telephone Number: \_\_\_\_\_

I/we acknowledge that I/we have carefully read the foregoing medical authorization and know the contents thereof.  
 Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Other Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_