



SISKIYOU FAMILY YMCA

APPLICANT INFORMATION		
Name:		
Male Female <i>(Please circle)</i>	Date of birth:	Phone:
Current mailing address:		
City:	State:	ZIP Code:
Marital Statuses: <i>(Please circle)</i> Single Married Divorced Separated Unspecified		
Race: <i>(Optional) (Please circle)</i> Unspecified American Indian Alaskan Native African American/Black		
Asian/Pacific Islander Caucasian/White Hispanic Other		
E-Mail:		
EMPLOYMENT INFORMATION		
Current employer:		
Employer address:		
City:	State:	ZIP Code:
Phone:	Position:	
EMERGENCY CONTACT		
Name of emergency contact:		Phone:
Relation to primary: <i>(Please circle)</i> Self Spouse Son Daughter Parent Dependent		
Domestic Partner Sibling Grandparent Guardian Family Member Other		
ADDITIONAL ADULT INFORMATION IF JOINT MEMBERSHIP		
Name:		
Male Female <i>(Please circle)</i>	Date of birth:	
Race: <i>(Optional) (Please circle)</i> Unspecified American Indian Alaskan Native African American/Black		
Asian/Pacific Islander Caucasian/White Hispanic Other		
E-Mail:		
ADDITIONAL ADULT EMPLOYMENT INFORMATION		
Current employer:		
Employer address:		
City:	State:	ZIP Code:
Phone:	Position:	
EMERGENCY INFORMATION		
Medical Problems:		
Medications:		
Allergies:		
Doctors Name:		Doctors Phone:

CHILDREN IF MEMBERSHIP PRIVILEGES DESIRED

Child/ren Live/s With: <i>(Please circle)</i>	Both Parents	Mother	Father	Grand Parent/s
Guardian	Other: _____			

Who is Guardian: <i>(Please circle)</i>	Both Parents	Mother	Father
Other: _____			

Name:	Birth date:
Male Female <i>(Please circle)</i>	

Race: <i>(Optional) (Please circle)</i>	Unspecified	American Indian	Alaskan Native	African
American/Black				
Asian/Pacific Islander	Caucasian/White	Hispanic	Other	

Medical Problems:

Medications:

Allergies:

Doctors Name:	Doctors Phone:
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Name:	Birth date:
Male Female <i>(Please circle)</i>	

Race: <i>(Optional) (Please circle)</i>	Unspecified	American Indian	Alaskan Native	African
American/Black				
Asian/Pacific Islander	Caucasian/White	Hispanic	Other	

Medical Problems:

Medications:

Allergies:

Doctors Name:	Doctors Phone:
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Name:	Birth date:
Male Female <i>(Please circle)</i>	

Race: <i>(Optional) (Please circle)</i>	Unspecified	American Indian	Alaskan Native	African
American/Black				
Asian/Pacific Islander	Caucasian/White	Hispanic	Other	

Medical Problems:

Medications:

Allergies:

Doctors Name:	Doctors Phone:
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EMERGENCY CONTACT INFORMATION

Emergency Contact:	Phone:
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Relation to primary: <i>(Please circle)</i>	Self	Spouse	Son	Daughter	Parent
Dependent					
Sibling	Grandparent	Guardian	Family Member	Other	

Emergency Contact:		Phone:	
Relation to primary: <i>(Please circle)</i> Self Spouse Son Daughter Parent Dependent			
Sibling Grandparent Guardian Family Member Other			
ADDITIONAL AUTHORIZED PICK-UP INFORMATION			
1st Authorized Pick-Up			
First Name:		Last Name:	
Current Address:			
City:	State:	Zip Code:	
Phone:		2 nd Phone:	
Relation to child?			
2nd Authorized Pick-Up			
First Name:		Last Name:	
Current Address:			
City:	State:	Zip Code:	
Phone:		2 nd Phone:	
Relation to child?			
3rd Authorized Pick-Up			
First Name:		Last Name:	
Current Address:			
City:	State:	Zip Code:	
Phone:		2 nd Phone:	
Relation to child?			
4th Authorized Pick-up			
First Name:		Last Name:	
Current Address:			
City:	State:	Zip Code:	
Phone:		2 nd Phone:	
Relation to child?			

SIGNATURES	
PLEASE READ CAREFULLY AND SIGN BELOW	
I hereby apply for membership at the Siskiyou Family YMCA and signify that I agree with its principle and purposes. I also believe all the above information to be true and correct. I understand the Siskiyou Family YMCA	
<ul style="list-style-type: none"> • membership privileges are not subject to refund. • has the right to revoke this membership at any time with due cause. • is not responsible for injuries sustained while engaging in YMCA activities. • is not responsible for any personal property that is lost or stolen. • needs to be notified in writing 30 days before membership is canceled. • increases membership dues annually based on COLA (cost of living adjustment). 	
Signature of applicant:	Date:

AREAS OF INTEREST (PLEASE CIRCLE ALL THAT APPLY)

Aerobics – Group Ex.	Child Care	Family Rec.	Spinning	Coaching
Volunteerism	Strength Training	Parent – Child Programs	Fundraising	Sports
Teen Activities	Board Member	Summer Camp	Senior Programs	Aquatics
Resident Camp	Social Activities	Other: _____		

VOLUNTEER INTEREST (PLEASE CIRCLE ALL THAT APPLY)

Aerobics – Group Ex.	Child Care	Family Rec.	Spinning	Coaching
Volunteerism	Strength Training	Parent – Child Programs	Fundraising	Sports
Teen Activities	Board Member	Summer Camp	Senior Programs	Aquatics
Resident Camp	Social Activities	Other: _____		

Weight Room Orientation Waiver:

I hereby decline orientation of the Fitness and Weight Room equipment. I am aware that I may request complimentary orientation at any time.
 I am aware of the policies regarding conduct and usage of the Weight Room and Fitness Room.

Signed:

Date:
