MATEO POLICE ACTIVITIES LEAGUE

anklin Parkway, San Mateo CA 94403 650-522-7725 FAX 650-522-7551

www.sanmateopal.org

PAL Staff Only: **Shirt Size** ______
❑ New Member Shirt received _______

Membership Application (One application per child)

This information will be maintained in strict confidence and is not furnished or sold to anyone else. It is used solely to ensure successful programming.

PLEASE USE INK AND PRINT CLEARLY

❑ **New**
❑ **Renewal**

Child's Information

Child's First Name: ______________________________ **Child's Last Name:** ______________________________

Address: ______________________________ **City** ______________ **State** ________ **Zip** __________

Child lives with: ❑ *Both parents* ❑ *Mother* ❑ *Father* ❑ *Other:* ____________________

Father/Guardian's First Name: __________________ **Last Name:** __________________ **D.O.B** ____________

*Phone (Home)*______________*(Cell)*______________ *E-Mail*______________________________

Mother/Guardian's First Name: __________________ **Last Name:** __________________ **D.O.B** ____________

*Phone (Home)*______________*(Cell)*______________ *E-Mail*______________________________

Emergency Contact *(Other Than Parents or Guardian)* **Name**: ______________________________

*Phone (Home)*______________*(Cell)*______________*E-Mail*______________________________

Child's Birthdate: *Month*____*Date*____*Year* ________ **Age:** ____**Sex:** *Male Female* **School:** ______________**Grade:**________

Names of Siblings: ____

Family Demographics

Family Size: Total number of family members living in your household (adults and children including yourself): ________

Income: Please check the box that best describes your total household annual income before taxes

❑ *Below $10,000* ❑ *$10,001-$19,999* ❑ *$20,000-$27,449* ❑ *$27,450 - 45,749*
❑ *$45,750 - 73,199* ❑ *$73,200 - 91,499* ❑ *$91,500 and above*

Does your family qualify for the Reduced Lunch Program? ❑ *Yes* ❑ *No*

Ethnicity: Please check only one box that best describes your child's ethnicity.

❑ *Asian* ❑ *African American*
❑ *Caucasian* ❑ *Pacific Islander*
❑ *Hispanic* ❑ *Multiple / Mixed Race* *Other:* ____________________

Primary language spoken at home: ❑ *English* ❑ *Spanish* ❑ *Other (What language?)* ____________________

Parental status: Pick the one option that best describes your family at this time.

❑ *Single head of household* ❑ *Married* ❑ *Separated/Divorced* ❑ *Widowed* ❑ *Foster Parents* ❑ *Guardian* ❑ *Other*

To the extent allowed by law, I hereby absolve the San Mateo Police Activities League, its employees, agents, independent contractors, and officers from all liability which may arise as the result of my/our participation in activities I or any member of my family account attends or registers into; and, in the event that the above named participant is a minor, I and hereby give my permission for his or her participation as indicated and in so doing absolve the San Mateo Police Activities League, its employees, and officers from such liability. I am aware that if I have registered for a class involving physical activity, I have taken care to enroll at a class level appropriate to my/our physical abilities and/or medical condition. I understand that during the Police Activities League program and/or activity, my photograph and/or the photograph of my child may be taken by the Police Activities League, producers, sponsors, organizer, and/or assigns. I agree that my photograph and/or the photograph of my child, including video photography, film photography, or other reproduction of my likeness or the likeness of my child, may be used without charge by the Police Activities League, producers, sponsors, organizers and/or it's assigns for such purposed as they deem appropriate.

Signature ____ Date ____________________

SAN MATEO POLICE ACTIVITIES LEAGUE

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Medical Information & Treatment Release Form

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Name of PAL Applicant

Medical / Insurance Information

Do you have INSURANCE? _______ YES _______NO

Insurance Company ______________________________Policy Number ________________

Physician's Name ______________________________Phone # ________________

Preferred Hospital or Clinic ______________________________

Allergies for drugs or foods:______________________________

Important medical information, special medications, or special instructions we should be aware of:

____

List any restrictions to medical treatment: ______________________________

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MEDICAL RELEASE: AUTHORIZATION CONSENTING TO TREATMENT OF MINOR

I/We, the undersigned, parent(s) or legal guardians of ______________________________, a minor, do hereby authorize the staff of the City of San Mateo Police Activities League, or an authorized representative, as agent(s) for the undersigned, to consent to any X-Ray examination, anesthetic, medical or surgical diagnosis, treatment and hospital care which is rendered under the general or specific supervision of any physician and surgeon licensed under the provisions of the California Medicine Practice Act on the medical staff of a licensed hospital, whether such examination, diagnosis, or treatment is rendered at the office of said physician or at such hospital.

It is understood that this authorization is given in advance of any specific examination, diagnosis, treatment, or hospital care being required, and is given to provide authority and power on the part of our above named agent(s) to give specific consent to any and all such examinations, diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his best judgment may seem advisable.

Signature ______________________________Date ________________