



Greater Fall River RE-CREATION

45 Rock Street, Fall River, MA 02720
508-679-0922 – www.gfrrec.org

Membership Information Form

Confidentiality: Any confidential information requested is for our records and for the funding our organization receives. The answers you provide will be kept completely confidential. Your cooperation in providing this information is both appreciated and necessary.

MEMBER INFORMATION *(Please Print)*

First Name: _____ Middle Name: _____ Last Name: _____

Nick Name: _____ Date of Birth: ____ / ____ / ____ Gender: Male Female

School: _____ Grade: _____

PARENT/GUARDIAN *(Please Print)*

First Name: _____ Last Name: _____ Gender: Male Female

First Name: _____ Last Name: _____ Gender: Male Female

Address *(Line 1)*: _____

Address *(Line 2)*: _____

Address Type: Home Work Other _____

City: _____ State: _____ ZIP Code: _____

Phone Number: (____) _____ - _____

Phone Type: Cell Home Work

Phone Number: (____) _____ - _____

Phone Type: Cell Home Work

Email Address: _____

Email Type: Home Work Other _____

- Female Head Household
- Male Head of Household

Family Income:

- 16,900 or under
- 19,300 or under
- 24,100 or under
- 28,000 or under
- 29,900 or under
- 31,850 or under
- 36,150 or under
- 40,150 or under
- 43,400 or under
- 46,600 or under
- 49,800 or under
- 53,000 or under
- 55,920 or under
- 59,760 or under
- 69,400 or under
- 74,550 or under
- 79,700 or under
- 84,850 or over

of Family Members:

Race: *(Please check)*

- White
- Black/African American
- African American & White
- Hispanic
- Asian
- Asian & White
- American Indian & Black
- American Indian/Alaska Native
- Native Hawaiian/Pacific Islander
- Other _____

EMERGENCY CONTACT *(Please Print)*

First Name: _____ Last Name: _____ Relationship to Member: _____

Phone Number: (_____) _____ - _____ Phone Type: Cell Home Work

Program/Session	Fee
Membership Fee	

FOR OFFICE USE ONLY				
<input type="checkbox"/> EL	<input type="checkbox"/> VL	<input type="checkbox"/> OL	<input type="checkbox"/> L	<input type="checkbox"/> H

TOTAL FEES: _____

MEDICAL INFORMATION

Please list any current conditions, allergies, chronic ailments and/or physical or mental disabilities that may prevent or affect the member from participating fully in the above programming: _____

Please list any medications or pertinent information: _____

Please make checks payable to **Greater Fall River RE-CREATION** and deliver with form to: Greater Fall River RE-CREATION, 45 Rock Street, Fall River, MA 02720. We also accept cash & credit. **Payments are due in full at the time of registration.**

Pre-registration is required for all classes, clinics, and camps!

I have read the complete application, understand the policies of Greater Fall River RE-CREATION and request that my son/daughter or myself be admitted into membership. I have explained the rules to my son/daughter and agree that Greater Fall River RE-CREATION will not be responsible for any accident to them while on the premises or engaged in any of its activities away from Greater Fall River RE-CREATION. I give consent for photographs, in which my son/daughter and/or myself may appear, to be used in any way Greater Fall River RE-CREATION may care to use them. All registrations will have a processing fee for refunds. I understand that it may be required for my son/daughter to provide their report card for participation in certain programs.

_____	_____	_____
Member Name <i>(Please Print)</i>	Member Signature	Date
_____	_____	_____
Parent/Guardian Name <i>(Please Print)</i>	Parent/Guardian Signature	Date