

Are you enrolled in the Free/Reduced Lunch Program at school*? Yes No

*If you do not attend school currently, did you qualify for the Free/Reduced Lunch program when you were in school? Yes No

Insurance Status:

- Public insurance (MassHealth, Medicare, Commonwealth Health, etc)
- Commercial insurance (Blue Cross/Blue Shield, Harvard Pilgrim, etc.)
- No insurance

Regular Source of Healthcare:

- | | |
|---|--|
| <input type="checkbox"/> Bowdoin Street Health Center | <input type="checkbox"/> Private practice |
| <input type="checkbox"/> Codman Square Health Center | <input type="checkbox"/> Hospital-based clinic (e.g., BMC, Carney Hospital, etc) |
| <input type="checkbox"/> Dorchester House Multi-Service Center | <input type="checkbox"/> Emergency Department |
| <input type="checkbox"/> Other Community Health Center in Dorchester | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> Other Community Health Center outside Dorchester | <input type="checkbox"/> No regular source of healthcare |
| <input type="checkbox"/> School Based Health Center | |

Referral Source:

- | | |
|--|---|
| <input type="checkbox"/> Bowdoin Street Health Center | <input type="checkbox"/> Department of Children & Families |
| <input type="checkbox"/> Codman Square Health Center | <input type="checkbox"/> Department of Youth Services |
| <input type="checkbox"/> Dorchester House Multi-Service Center | <input type="checkbox"/> Family/friend |
| <input type="checkbox"/> Upham's Corner Health Center | <input type="checkbox"/> School |
| <input type="checkbox"/> Dorchester Youth Collaborative | <input type="checkbox"/> Other DotWell program (please specify) _____ |
| <input type="checkbox"/> St. Peter's Teen Center | <input type="checkbox"/> Other agency (please specify) _____ |
| <input type="checkbox"/> Court/Probation | <input type="checkbox"/> NA |

Registered to Vote: Yes No Not Applicable

Parent/ Guardian Information

Parent/ Guardian One

Parent/ Guardian Name: _____

Relationship to Child: _____

Phone Numbers: Home: _____

Work: _____

Cell: _____

E-mail: _____

Parent/ Guardian Two

Parent/ Guardian Name: _____

Relationship to Child: _____

Phone Numbers: Home: _____

Work: _____

Cell: _____

E-Mail: _____

Emergency Contact

Emergency Contact Name: _____

Relationship to Child: _____

Phone Numbers: Home: (_____) _____ - _____

Work: (_____) _____ - _____

Cell: (_____) _____ - _____

Authorization and Release Form

I give my child permission to participate in the activities offered by DotWell youth services & recreational programs such as gym, male/ female focus groups, dance, sports & fitness, computers, art, and field trips. My child has no physical problems that would prohibit him/ her from doing so. I understand that all activities are supervised.

I understand that the Teen Center will take all precautions to guard my child's safety while he/she is participating in events.

However, I understand that in all sports and physical activity, there is a certain amount of risk. I waive all claims against any and all persons connected with the Teen Center for any injuries sustained during any center-sponsored activity. I assume all responsibility for my child's actions during and in conjunction with the Teen Center and waive compensation in regard thereof.

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child.

However, if I cannot be reached, I hereby authorize the Teen Center to transport my child to the nearest hospital or medical facility, and secure for my child the necessary medical treatment.

I understand that the Teen Center staff is trained in the basics of first aid and authorize them to give my child first aid when appropriate.

I permit the Teen Center to use photographs that may contain my child's picture for promotional purposes. I also permit the Teen Center to transport my son/ daughter to outside activities organized and/ or supervised by the Teen Center.

My child is in good physical health: Yes No Date of last physical exam: _____

My child is taking the following medication(s): _____

 If so, medication is for conditions related to: _____

My child is allergic to the following: _____

My child has the following reactions to his/her allergies: _____

Please list any behavioral, social, emotional, mental concerns, dietary restrictions etc. that your child may have: _____

Health insurance plan: _____ Policy# _____

Name of hospital/clinic: _____

Name of child's doctor: _____ Doctor's Phone number: (_____) _____

In the event of an emergency we ask that you provide the health insurance information in case your child has to be transported to a health care facility/hospital. He/she will be transported to the nearest health care facility/hospital.

Parent/Guardian Signature: _____ **Date:** _____