



LIFT FOR LIFE GYM MEMBERSHIP APPLICATION
APPLICATION MUST BE COMPLETED IN FULL

Member Information (Child):

First Name: _____ Middle: _____ Last Name: _____

Pick Up Password: _____ (To be used if someone other than parents pick up.)

Birth Date: _____ Age: ____ Gender: _____ Ethnicity: _____

School: _____ Grade Level: _____

Does your child have an Individualized Education Plan (IEP)? Yes _____ No _____

Shirt Size: XS S M L XL Youth _____ Adult _____

Is your child currently a member at LFLG? Yes or No

Head of Household (Parent/Guardian):

First Name: _____ Last Name: _____ Gender (Please Circle): M / F

Address: _____

City: _____ State: ____ Zip Code: _____

Home Phone Number: (____) ____ - _____ Cell Phone Number: (____) ____ - _____

Work Phone Number: (____) ____ - _____ Email Address: _____

Employer/School Attended: _____ Family Size: _____

Other Parent/Guardian/Emergency Contact:

First Name: _____ Last Name: _____ Gender (Please Circle): M / F

Address: _____ City: _____ State: ____ Zip Code: _____

Home Phone Number: (____) ____ - _____ Cell Phone Number: (____) ____ - _____

Work Phone Number: () ____ - _____ Email Address: _____

Employer/School Attended: _____

Head of Household Work/School Schedule

Mon: Tues: Wed: Thurs: Fri:

Other Parent/Guardian/Emergency Contact Work/School Schedule

Mon: Tues: Wed: Thurs: Fri:

Family Demographics:

Family Income (Please Circle): \$0 - \$9,999 \$10,000-\$14,999 \$15,000-\$19,999
\$20,000-\$29,999 \$30,000-\$49,999 \$50,000-\$99,999 \$100,000 or above

Family Setting: Biological ____ Adoptive ____ Grandparents ____ Foster ____ Other ____

List your other children who attend LFLG:

Medical Information

Does your child have medical insurance? Yes ____ No ____

Where does your child go to basic medical services? Primary Care Physician ____ Clinic ____ Hospital ____

Physician/Clinic/Hospital Name:

Physician/Clinic/Hospital Phone Number:

Primary Insurance Company:

Does your child see a dentist at least once a year? Yes ____ No ____

Member Usage (Please Write In Estimated Time Range):

Mon: Tues: Wed: Thurs: Fri:

Medical Diagnosis(s) (Please Check):

ADD ____ ADHD ____ Autism ____ Asperger's ____

Asthma ____ Allergies (Please List): _____

Does your youth have any food allergies? _____ if so, please list _____

Other (Please List):

******PLEASE NOTE: If your child has asthma or food allergies, we must have an inhaler or EpiPen on site before your child can begin the program.**

Does your youth currently take medication? _____ if yes, please list _____

Comments on Child's Development:

Please list any personal development issues, behaviors, habits, or individual needs that LFLG needs to be aware of when in custody of your child:

Lift For Life Gym is not a behavioral facility and, therefore, does not offer one-on-one assistance to members who may require it.

Pick Up/Emergency Contact Information (Two Additional Persons Authorized to Take Child From Facility):

Name: _____ Relationship to Child: _____

Address: _____ City: _____ State: ___ Zip Code: _____

Home Phone Number: (____) _____ - _____ Cell Phone Number: (____) _____ - _____

Name: _____ Relationship to Child: _____

Address: _____ City: _____ State: ___ Zip Code: _____

Home Phone Number: (____) _____ - _____ Cell Phone Number: (____) _____ - _____

Emergency Contact? Yes _____ No _____

Authorization for Emergency Medical Care:

I understand that I will be notified at once in case of an emergency with my child, and I will make arrangements for medical care of my child with the physician or hospital of my choice.

If I cannot be reached to make necessary arrangements, or in critical emergency requiring medical care, I authorize Lift For Life Gym to contact the closest Medical Center.

Please Initial: _____

Photo, Video and Audio Consent and Release:

By initialing below, I consent and give permission to allow LFLG the unlimited right to use photos, videos, direct quotes and/or audio clips that they have of my child participating at LFLG programs or events for our newsletters, website and other promotional literature.

Please Initial: _____

***This information is very helpful to us for future funding:**

Does your child receive Free or Reduced-Price Lunches at school? Yes _____ No _____

Does your child receive Medicaid? Yes _____ No _____

Permission for Member (Please Check):

Is your child allowed to swim? Yes _____ No _____

Do you give LFL Gym consent to transport your child on our van and buses for field trips and outings? Yes _____ No _____

Is your child allowed to weightlift and participate in fitness and team sports programming? Yes _____ No _____

Do you give LFL Gym consent to take photos or video of your child to use in our newsletters, website and other promotional literature? Yes _____ No _____

By signing below, I agree to all terms and conditions of this application

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

OFFICE USE ONLY

Start Date: _____

New _____ **Returning** _____

Parent/Guardian Questionnaire

Dear Parent/Guardian,

You play a very important part in the success of our program. Please complete the following questions. This information will help us to properly match your child with a mentor.

Describe how your child is doing in school _____

Describe your child's personality (outgoing, introverted, shy, friendly, confident, stubborn, etc.)

Describe the type of mentor that would best suit your child _____

Do you have a concern regarding the ethnicity/gender of your child's mentor? _____

If yes, please explain _____

What do you hope your child will gain from having a mentor? _____

Do you have any concerns about your child having a mentor? _____

If yes, please explain _____

Are there any factors that would prevent your child from participating in this program (transportation or any other responsibilities)?

Additional comments:
