

**HUDSON GUILD BEACON  
2008-2009 REGISTRATION FORM  
Adult Enrollment Form  
18 and Over**

**Activity Name:** \_\_\_\_\_

**Participant Information**

1. Last Name \_\_\_\_\_ 2. First Name \_\_\_\_\_
3. Gender Male Female 4. Birth Date (month/day/year) \_\_\_\_\_
5. Street Address (number and street) \_\_\_\_\_ Apt # \_\_\_ Zip code \_\_\_\_\_
6. Ethnicity American Indian Asian (Non-Hispanic) Black (Non-Hispanic)  
Hispanic/Latino Pacific Islander White (Non-Hispanic)  
Other
7. Primary Language \_\_\_\_\_ Home Phone # ( ) \_\_\_\_\_ - \_\_\_\_\_
- # of people living in Household: \_\_\_\_\_ Total Family Income: \_\_\_\_\_
- Entitlements: \_\_\_\_\_ Food Stamps \_\_\_\_\_ Medicaid \_\_\_\_\_ TANF \_\_\_\_\_ PA \_\_\_\_\_ SSI/D

**Emergency Contact Information**

Persons authorized by you to be contacted in case of emergency.

8. Emergency Contact Name: \_\_\_\_\_  
Relationship \_\_\_\_\_  
Home Phone Number \_\_\_\_\_  
Cell Phone Number \_\_\_\_\_
9. Emergency Contact Name: \_\_\_\_\_  
Relationship \_\_\_\_\_  
Home Phone Number \_\_\_\_\_  
Cell Phone Number \_\_\_\_\_

**Health History**

10. Are you or any member of your household covered by Medicaid, Child Health Plus, Family Plus or private medical insurance?

- Yes  
 No

If no, do you want to be contacted with information about public health insurance programs?  Yes  
 No

Please list any allergies or health issues that we should be made aware of in case of emergency:


Do you live in a Public Housing Development? If so, please check: **Elliott Chelsea:** \_\_\_\_\_ **Fulton:** \_\_\_\_\_ **Other:** \_\_\_\_\_

# of people living in Household: \_\_\_\_\_ Total Family Income: \_\_\_\_\_

Move in date (required): \_\_\_\_\_

**Picture Consent:**

I give permission to Hudson Guild programs to use my pictures to help publicize Hudson Guild programs.

**Signature of Participant:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Certification Statement**

I, the undersigned, certify that all information on this form is true and correct. I understand that my statements are subject to verification. I agree and accept that I will abide by all applicable rules and regulations of the program. I consent to the enrollment and participation in this program.

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_  
Intake Officer Signature \_\_\_\_\_ Date \_\_\_\_\_