2025 Youth Program Staff

(Over 18)

A copy of this publication is available in alternative format upon request.

PERSONAL, FAMILY, AND EMERGENCY CONTACT INFORMATION

Name (first & last): _____

_____

Street Address **Apt. #**

_____

City **State** **Zip Code**

Cell Phone # (if applicable): _____

Date of Birth: _____ **Gender: male**_____**female**_____

Emergency Contact #1: _____

Name (first & last): _____

_____

Street Address **Apt. #**

_____

City **State** **Zip Code**

Home Phone #: _____ **Work Phone #:** _____

Cell Phone #: _____

Relationship: _____

Emergency Contact #2

Name (first & last): _____

_____

Street Address **Apt. #**

_____

City **State** **Zip Code**

Home Phone #: _____ **Work Phone #:** _____

Cell Phone #: _____

Relationship: _____

PLEASE READ THE FOLLOWING RELEASES CAREFULLY AND PROVIDE A SIGNATURE FOR EACH SECTION BELOW.

GENERAL RELEASE

I, _____,(staff member) are participating in _____(insert program name) Program, on behalf of myself, my family, my heirs, representatives, assigns, executors or administrators, I hereby release and agree to hold UMass Boston, its trustees, directors, officers, employees, servants, representatives, agent licensees, successors and assigns, harmless from and against any and all claims, losses, damages, expenses (including attorneys' fees, and all court and litigation costs) and liability (including statutory liability), resulting from injury and/or death of any person or damage to or loss of any property arising out of or in any way from the _____(insert program name) Program and my participation therein.

_____

Signature **Printed Name** **Date**

HEALTH HISTORY

Name (first & last): _____

Have you had, or do you have, any of the following? Circle one YES NO

If yes, please explain on a separate sheet of paper.

	YES	NO		YES	NO
Medication allergies:			Asthma		
Food allergies or special diet			Easy Bleeding		
Seizures/epilepsy/fainting spells			Emotional/psychiatric/behavioral issues		
Diabetes			Sickle cell trait or disease		
Concussion or serious head injury			High blood pressure		
Heat stroke/exhaustion			Heart disease/ heart defect		
Contact lenses/glasses			Any limitations that restrict running, swimming, participating in group recreational activities?		

Use this space to provide any additional information on your physical health about which the program at UMass Boston should be aware:

_____

_____

_____

Signature **Printed Name** **Date**

HEALTH INSURANCE INFORMATION

Please include a copy of your health insurance card. If you cannot provide the requested health insurance card; please provide the following insurance information:

Insurance Carrier Policy Number

Cardholder's Name

IMMUNIZATIONS

Please fill out the information below or <u>provide a copy of your immunization records</u>.

Name: _____

Date of birth: _____

MEASLES, MUMPS AND RUBELLA (MMR) VACCINE
First dose must be after age 12 months; 2 doses required.

MMR #1 ____/____/____ MMR #2 ____/____/____

POLIO VACCINE
A minimum of three doses of either inactivated polio vaccine (IPV) or oral polio vaccine (OPV) are required. If a mix of (IVP/OPV) was used, four doses are required.

Completed primary series of polio immunizations? ☐ ☐
Dates:

YES NO
____/____/_____
____/____/_____
____/____/_____
____/____/_____

DIPHTHERIA AND TETANUS TOXOIDS AND PERTUSSIS VACCINE
Minimum of four doses of DTaP/DTP/DT or at least three doses of Td is required. A booster dose of Td is required for all program participants who will be entering grades seven through 10. For participants who will be entering grades 11 and 12, a booster of Td is required if it has been more than 10 years since the last dose of DTaP/DTP/DT/Td. (Tdap is also acceptable.)

Completed primary series of DTaP/DTP/DT? ☐ YES ☐ NO

Dates: ___/____/_____ ____/____/_____ ____/____/_____ ____/____/_____

Date last Td ____/____/_____

HEPATITIS B

Three doses of Hepatitis B vaccine are required if born on or after Jan. 1, 1992.

Dose # 1 ____/____/____Dose #2 ____/____/____Dose #3____/____/____

COVID-19 (optional)

Two doses of the Moderna or Pfizer vaccine are required OR one dose of the Johnson and Johnson vaccine

Dose # 1 ____/____/____Dose #2 ____/____/____

And at least one booster dose

Dose # 1 ____/____/____Dose #2 ____/____/____

EXCEPTIONS

• RELIGIOUS OBJECTION: The individual must submit a written statement, signed by a parent/guardian if a minor, to the effect that the individual is in good health and stating the reason for such objections.

• MEDICAL: The individual must submit certification by a physician stating that the physical condition of the individual is such that his or her health would be endangered by such immunization.

Healthcare Provider Signature	**Printed Name**	**Date**

Address: _____

_____

Phone number: _____