# 2026 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**: _____