



## The Pilot House

*Special Needs  
Resource Foundation*

[thepilothouse.org](http://thepilothouse.org)

# MEMBERSHIP FORM

Please fill out this form completely so we can process your membership. All information provided will be for the private use of The Pilot House and will not be shared with any third parties.

## Family Membership

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Parent/Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone number: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Email \_\_\_\_\_ (email is our primary form of communication with the membership)

## Child/children

Name \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_

## Educator/ Service provider Membership

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Name: \_\_\_\_\_

Profession: \_\_\_\_\_

Address \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email: \_\_\_\_\_ (email is our primary form of communication with the membership.)

**Annual Membership fee \$35.00 (July1st – June30th)**

**Please send to:**

**The Pilot House  
240 Colony Street  
Fairfield, CT 06824**

**REGISTRATION AND EMERGENCY INFORMATION**      **SIDE 1**

\_\_\_\_\_  
Child's Name

\_\_\_\_\_  
D.O.B.

\_\_\_\_\_  
Age

\_\_\_\_\_  
Grade

\_\_\_\_\_  
Parent's / Guardian's

\_\_\_\_\_  
Name Parent's / Guardian's Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, Zip code    City, Zip code

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Cell Phone

\_\_\_\_\_  
Emergency number

\_\_\_\_\_  
Email Address

**MEDICAL INFORMATION**

\_\_\_\_\_  
Pediatrician Name

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Dentist Name

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Preferred Hospital

\_\_\_\_\_  
Insurance Company Policy number

\_\_\_\_\_  
Diagnosis

\_\_\_\_\_  
Allergies / Special Health Considerations

**PLEASE COMPLETE BOTH SIDES OF INFORMATION**

TELL US MORE ABOUT YOUR CHILD SIDE 2

Child's Name: \_\_\_\_\_

Child's likes: \_\_\_\_\_ Child's dislikes: \_\_\_\_\_

\_\_\_\_\_

Child's strengths: \_\_\_\_\_ Concerns: \_\_\_\_\_

\_\_\_\_\_

Child's reinforcement: \_\_\_\_\_

Level of supervision needed: High Medium Low

Child's safety awareness: Good Fair Poor

PROGRAM SELECTION AND WAIVER INFORMATION

\_\_\_\_\_ Day/ Time Cost \_\_\_\_\_  
Program selection

\_\_\_\_\_ Day / Time Cost \_\_\_\_\_  
Program selection

\_\_\_\_\_ Day / Time Cost \_\_\_\_\_  
Program selection

Credit Card Type (circle): Mastercard Visa Amex Discover Total \_\_\_\_\_

Card # \_\_\_\_\_ expiration date: \_\_\_\_\_

Card Security # \_\_\_\_\_

**(Last three digits located on the back of card or for Amex 4 digits located on the front)**

I hereby certify the minor is my son/daughter and that his/her date of birth is noted above and I do hereby certify that to the best of my knowledge and belief said minor is in good health. I understand the policies as stated on this form/registration. I understand the risks to my child in participating in activities, particularly physical activity. I take responsibility for these risks and agree to indemnify and hold harmless TPH and its officers, the Town of Fairfield, and the staff in the event my child sustains an injury. Program fees are **non-refundable**.

In case of illness or accident, permission is granted for emergency treatment to be administered. It is further understood that the undersigned will assume full responsibility for any such action, including payment of costs. I hereby advise that the above named minor has had the following allergies, medicine reactions or unusual physical conditions which should be made known to a treating physician.

Photos are taken during programs for use of slide shows, scrap books, social story stories and grant applications. In the event that you **do not want photos** to be taken, please initial \_\_\_\_\_.

Name of Parent / Guardian **(Please Print)** \_\_\_\_\_

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Please send and make checks payable to:  
The Pilot House  
240 Colony Street  
Fairfield, CT 06824