



**Hawaiian Kamali'i, Inc. dba Hawaiian Canoe Club**

P.O. Box 5053 · Kahului, Maui, Hawai'i · 96733

Phone 893-2124 · Fax 893-2047

[www.hawaiiancanoeclub.org](http://www.hawaiiancanoeclub.org)

**Keiki Membership Form**

**Keiki Information**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Check one:  Male  Female Email address \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Birth date \_\_\_\_\_ (mm/dd/yyyy)

School attending for 2009-2010: \_\_\_\_\_ Grade \_\_\_\_\_

Has the keiki participated in the Kamali'i Program before?  Yes  No

If yes, how many years has keiki participated in the Kamali'i Program \_\_\_\_\_

*Ethnicity* (check all that apply)

- Caucasian  Hawaiian  Japanese  Chinese  Korean  Filipino  Other Asian  
 Hispanic  African American  American Indian  Samoan  Tongan  
 Other Pacific Islander \_\_\_\_\_  Other \_\_\_\_\_

*Citizenship*

- U.S. Citizen  Other \_\_\_\_\_

*Annual Family Income*

- Under \$12,000  \$12,001 - \$25,000  \$25,001 - \$45,000  over \$45,000

*With whom does the child live with?*

- Parent(s)  Grandparent(s)  Other Family  Foster Parent(s)  Other \_\_\_\_\_

*Does the keiki cope with any of the following? If yes, attach necessary details on a separate sheet.*

- A current illness  A disability/chronic illness  Any allergic condition  
 Asthma (include asthma plan)  Attention deficit disorder (ADD/ADHD)  
 Behavioral problems  Diabetes  Epilepsy  
 Sleep walking  Skin condition

Please identify any conditions, needs, or requirements not listed above \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please complete the back of this form

**Parent/Guardian Information**

Primary Guardian Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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

Employer \_\_\_\_\_ Position \_\_\_\_\_

Secondary Guardian Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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

Employer \_\_\_\_\_ Position \_\_\_\_\_

**Emergency Contact** (other than parents/guardians)

Primary

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Secondary

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**Risk Waiver and Media Consent**

a) I agree to my keiki’s attendance at the Hawaiian Kamali‘i Program. In the case of an emergency, I authorize the program staff, where it is impracticable to communicate with me, to arrange for my keiki to receive such medical or surgical treatment as may be deemed necessary. I also undertake to pay or reimburse costs which may be incurred for medical attention, ambulance transport and drugs while my keiki is enrolled with the program. I understand that although Hawaiian Kamali‘i and its service providers attempt to minimize any risk of personal injury within practical boundaries, accidents do happen and all physical activities carry the risk of personal injury. I acknowledge that there is an inherent risk of personal injury in physical activities that will be undertaken as part of this program, and

b) Please check:

I consent /  I do not consent to allow Hawaiian Kamali‘i and its service providers to use my keiki’s name and any photographs, sound, and film recordings taken of my keiki at this program for the promotion of Hawaiian Kamali‘i to the media and to the general public.

Print full name \_\_\_\_\_ Signature \_\_\_\_\_