

Program Registration Form



Pines Community Center

Participant Name _____ D.O.B. _____ Gender _____

Name of Program _____ Shirt Size _____ Current Grade _____

Participant's Town of Residence _____ Person Responsible for Payment _____

Mother Information

Name _____ Mailing Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

e-mail _____

Father Information

Name _____ Mailing Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

e-mail _____

Emergency Contact _____ Relation _____ Phone # _____

Medical Release Agreement

In the event of an emergency and none of the parents, guardians, or emergency contacts listed above are able to be reached, I/We hereby give permission to the employees of the Tilton-Northfield Recreation Council to call rescue personnel. I/We further authorize the appropriate medical personnel to treat, hospitalize, and administer anesthesia, and order injections or surgery for the safety of the participant.

Participant & Parental/Guardian Statement of Agreement

Participation in this sport/activity may involve risk of injury. As a parent or participant, I am aware of these hazards and my ability to participate. In consideration in the program(s) listed above, I hereby for myself, my heirs, executors and administrators waive and release all rights and claims against the Pines Community Center (P.C.C.)/Tilton-Northfield Recreation Council, it's officers, employees, agents, volunteers, and supervisors, except in the case of their sole negligence, from all losses, injury, damages, fees and other expenses, arising out of or in connection with participation in the activity.

All Pines classes/events may be photographed. Participants may be photographed for the P.C.C. programs and promotions. I acknowledge that a \$15 fee will be charged for any returned check.

By Signing below I confirm that I have read and understand all of the information in this document and I accept the Medical Release Agreement and the Participant & Parental Statement of Agreement.

Signature _____ Date _____

Arrival and Departure Information

Please circle your child's method of arrival: Walk Bicycle Dropped off Arrival Time_____

Please circle your child's method of departure: Walk Bicycle Picked Up Departure Time_____

Please list any special concerns or considerations that involve the arrival and departure of the participant. For example: can not be picked up by ..., must call before they leave, never allowed to walk; etc.

Please list all people who might be picking up the participant.

WE ID: We will I.D. anyone who we do not know or recognize.

Medical Information

Participant Name _____ Date of Last Tetanus Shot_____

Primary Physician _____ Phone Number _____

Health Insurance Company Name _____ Policy Number _____

Allergies: Does the participant have any allergic reactions (e.g., to bees, drugs, food, etc.)?

Chronic Illnesses: Does the participant have any chronic illnesses (e.g., diabetes, epilepsy, asthma, fainting, heart trouble, etc.)?

Physical Conditions: Does the participant have any physical difficulties (e.g., eyes, ears, nose, throat, lungs, etc.) that may limit their participation?

Medications: Does the participant take any medications (e.g., Tylenol, Ritalin, bee sting kit, etc.)? If yes, please list below. Under no circumstances are any children allowed to have any type of medication with them at any of our programs. **If medication needs to be administered during the day please fill out a medication policy form.**

Does the participant have any physical, medical, or emotional conditions not listed above that would prohibit, limit, or effect their participation in this activity?

Please Circle the appropriate answer: **NO** **YES** **If yes, please explain below.**