

PLEASE CHECK REGISTRATION DATES. PLEASE PRINT CLEARLY!

MAIL TO:

Willington Parks & Recreation Department
 40 Old Farms Road, Willington, CT 06279

Primary Household Contact (Parent/Guardian)

Name: _____

Address _____

Town: _____ Zip: _____

Phone: (H) _____ (W) _____

(Cell) _____

Email Address: _____

Secondary Household Contact (Parent/Guardian)

Name: _____

Address: _____

Town: _____ Zip: _____

Phone: (H) _____ (W) _____

(Cell) _____

Email Address: _____

LOCAL Emergency Contact (Other than parent/guardian, i.e. grandparent, neighbor, etc.)

Name: _____

Phone: _____

Program Name	Start Date	Participant's Last Name	First Name	Birth Date	Gender	Fee
A scholarship fund has been established for lower income children.				Contribution to Scholarship Fund		
DEPENDING ON PROGRAM OR TRIP PLEASE ADD:				Non Resident \$5.00 OR \$10.00 Additional per person/ per/ activity		
TOTAL						

Some Willington residents may be eligible for low-income fee reductions. Check with the Parks & Recreation Office for more information and an application.

Also fill details below for each participant:

	Grade Entering	Name of Doctor and phone number	Allergies, Special Asst., Meds, Other Info:
1.			
2.			
3.			
4.			

PAYMENT INFORMATION: Please make checks payable to: Willington Parks and Recreation Department (WPRD)
 (Separate checks required for each program)

Release, Waiver and Assumption of Liability and Consent For Medical Treatment

I, the undersigned, by registering myself or my child in the town's programs/trips understand the nature and risks associated with the participation in this activity. I hereby grant my child permission to participate. I am aware that participation is at one's own risk. I acknowledge that the activity, equipment and facilities may pose a risk of personal injury. I am also aware that each participant is responsible for his or her own safety. I hereby waive and release myself, my heirs, executors or administrators of any and all claims and damage we ever had or now have, against the Town of Willington, its successors and assigns, employees, agents and representative for any and all kinds of injury, including but not limited to personal injury and/or property damage suffered by my child, myself, family members or friends while participating in this program. Consent for Medical Treatment of Minors, as the parent or legal guardian of the above named player, I hereby give consent for emergency medical care prescribed by a fully licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve the life, limb or well being of my dependent. I certify that the information contained on this form is accurate and complete.

Signature: _____ Date: _____

Office Use Only: Payment Method: Check _____ Cash (in office only) _____ Amount Paid _____ Date Paid _____