

**WILLINGTON PARKS & RECREATION DEPARTMENT PROGRAMS
REGISTRATION FORM**

Participant Information – Please Complete One Form for Each Participant

I am registering for (name of program/event): _____

Name: _____ Gender: M F
(First) (Last)

Address: _____

Town _____ State _____ Zip _____ Date of Birth: _____

Home Phone: _____ Alt. Phone: _____

Parent/Guardian Name(s) _____

Email Address: _____

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

I, the undersigned, by registering myself or my child in a town program, 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 of Medical Treatment of Minors, as the parent or legal guardian of the above named participant, 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.

Date: _____ Signature: _____
(Parent/Guardian if participant is under the age of 18)

REFUND POLICY: There are no refunds except for medical reasons, upon receipt of a physician's note.

Emergency/Medical Information

In case of emergency contact:

Name: _____

Home Tele: _____ Bus. Tele: _____ Relationship: _____

Physician's Name: _____ Tele: _____

Allergies, Medical Conditions & other info: _____
