

Philipstown Recreation Department

2010 YOUTH PROGRAM REGISTRATION

PLEASE PRINT CLEARLY:

First Name _____ Last Name _____

Address _____

Grade _____ Date of Birth _____ Male _____ Female _____

Phone (H) _____ (W) _____ Emergency _____

Allergies/Comments _____

Email Address _____

PROGRAMS/SESSIONS YOU ARE REGISTERING FOR:

- 1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

[] My child is in 6th grade or above and has the right to be released from any program on their own at their sole discretion.

[] The Philipstown Recreation Department reserves the right to photograph, video or record any Recreation Program and use for future promotions. Please check this box if you do not want your child's picture to be used.

MAKE CHECKS PAYABLE TO: Philipstown Recreation Department, PO Box 155, Cold Spring, NY 10516

*All outstanding bills must be paid before participating in new programs. Please call the Recreation Department if you wish to set up a payment plan; inquiries are confidential.

REFUNDS/CREDIT:

Refunds will be issued to all registrants in case of program cancellation by the Recreation Department. Refunds, at registrants requests, may be made up to one week prior to start of a program. Participants may be offered a pro-rated credit towards future recreation fees if a documented medical problem prevents completion of a program.

I/We the undersigned, Parent(s) or Legal Guardian of the above named, a minor, do hereby attest that my child is physically able to participate in the above program(s) and I/we authorize Philipstown Recreation Department and staff as our agent(s) to consent to any medical procedures or medical care which is deemed advisable by, and is to be rendered under the general or special supervision of, any licensed physician or surgeon. It is understood that this authorization is given in advance of any specific need of treatment but is given to provide any authority on the part of the aforesaid agent(s) to give consent to any and all such procedures, treatment, or hospital care which the physician, or surgeon in the exercise of his/her best judgement may deem advisable. This authorization shall remain effective from January 1, 20__ through December 31, 20__.

(Print Name) Parent/Legal Guardian (Signature) Parent/Legal Guardian Date