Philipstown**Recreation**Department

2013 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/SUGGESTIONS YOU ARE REGISTERING FOR:

1._____ 2._____

3._____ 4._____

5._____ 6._____

7._____ 8._____

9._____ 10._____

_____ My child is in the 6th grad or above and have 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, New York, 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/Credits: Refunds will be issued to all registrants incase of program cancellation by the Recreation Department. Refunds, at registrants request, 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 problem prevents completion of a program. **There is a 15% administrative fee for all refunds and withdrawals issued less than one week prior to the start of the program. Once the program has begun, there are no refunds except for documented medical reasons. If you no show for a program and do not have a documented medical reason, you will be responsible for the entire cost.**

1/we undersigned, Parent(s) or Legal Guardian of the above named, a minor, do herby 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 licensed physician or surgeon. It is understood that this authorization is given in advance of any special 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 with the physician, or surgeon in the exercise of his/her best judgment may deem advisable. This authorization is effective for one year after the signature date.

_____ _____ _____

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