

Park & Recreation Activity Registration
1700 River Drive North
771-1265

FOR OFFICE USE ONLY

Date registration received:

Total Paid:

CHILD INFORMATION

LAST NAME: _____ M.I.: _____

FIRST NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

AGE: _____ GRADE ENROLLED IN NOW: _____

DATE OF BIRTH: _____ M/F: _____

CUSTODIAL PARENT(S)/ GUARDIAN:

NAME: _____

DAY PHONE: _____ EVENING PHONE: _____

NAME: _____

DAY PHONE: _____ EVENING PHONE: _____

MAY YOUR CHILD BE RELEASED TO ANYONE OTHER THAN THE CUSTODIAL PARENT/GUADIAN

Yes No

If YES, please list names and relationship to child: _____ Great Falls Gymnastics Academy

EMERGENCY CONTACT IF PARENTS CANNOT BE REACHED:

NAME: _____

DAY PHONE: _____ EVENING PHONE: _____ CELL PHONE: _____

CHILDS HEALTH STATEMENT: I/We the undersigned understand that physical activity is a regular part of the program. To the best of my knowledge, my child is in excellent physical health and needs no restrictions (except what is listed under "special problems") from activity. If I have any questions regarding my child's health, I understand that it is my obligation to seek professional medical advice and to inform the Park & Recreation Department of any restrictions on my child's activities.

Parent/Guardian Signature: _____

ANY MEDICAL/BEHAVIORAL/DEVELOPMENTAL CONDITIONS THAT SHOULD BE BROUGHT TO OUR ATTENTION: _____

HAS CHILD PARTICIPATED IN THIS ACTIVITY BEFORE Yes No

CHECK ACTIVITY YOUR CHILD WILL BE PARTICIPATING IN:

Swim Lessons **Great Falls Gymnastics Academy**

I agree to indemnify and hold the City of Great Falls and any cooperating agencies involved in the activities and any of their servants, officials, or employees, free and harmless from any liability, loss, cost, or expense including attorney fees, which may result from participation in the activity. I agree that I am fully responsible for payment of all costs resulting from the rendering of medical aid and ambulance services to the listed participant, and I authorize that all necessary first aid steps may be taken as prescribed by qualified personnel. I grant full permission to use photographs, videotapes, recording or any other record of this program for any purpose. By signing below, I agree that I understand and consent to this statement.

Parent/Guardian Signature: _____