



# PROGRAM REGISTRATION FORM

P.O. Box 26 • 401 N. Madison, Rm. 18 • Spring Hill, KS 66083  
Phone: (913) 592-2214 • Fax: (913) 592-2910 • Website: www.springhillrec.org

Name of Activity, Program or Sport	Session

Participants Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

GRADE: \_\_\_\_\_  Male  Female AGE \_\_\_\_\_

Parent(s) Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Parents, PLEASE would you help? Coach: \_\_\_\_\_ Assistant Coach: \_\_\_\_\_

Please List any special needs or accommodations : \_\_\_\_\_

**Emergency Authorization:** The undersigned parents of the above named participant hereby authorize the coaches, assistant coaches, parents of team members acting as activity supervisors or vehicle drivers, or Spring Hill Recreation Commission (SHRC) officials as agents for the undersigned to consent to emergency treatment of our minor child, the above named participant, as indicated below:

\_\_\_\_\_ In case of emergency, I (we) authorize treatment at any hospital  
\_\_\_\_\_ In case of emergency, if I (we) cannot be reached, please contact

\_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_ Other instructions: \_\_\_\_\_

**Waiver and Consent Statement:** I understand that by participating in these activities, I, my child or my dependent, accept the risk that injuries, damages, or even death may occur. In consideration of myself, my child or my dependent being allowed to participate in the Programs operated by the Spring Hill Recreation Commission (hereinafter "programs"). I forever release and hold harmless of myself, my heirs, executors, administrators, or assigns the Spring Hill Recreation Commission, any of it's employees, agents, representatives, coaches and volunteers from any and all liability for any injury, accident, illness, death, damage, loss or damage to personal property or any other loss of any kind suffered as a result of or in connection with me, my child or my dependent's participation in the Programs. Also, I understand that this activity may entail physical exertion; therefore a physician has approved the participation of my dependent or myself in this activity.

**Accommodation Statement:** If you require any accommodations in order to safely participate in this activity, please notify the SHRC at (913) 592-2214. Forty-eight (48) hour advance notice is required.

**I HAVE READ AND UNDERSTAND THE WAIVER AND ACCOMMODATION STATEMENTS.**

X \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of Parent/Guardian

<u>"Office Use Only"</u>		
Received By: _____	Date Received: _____	Receipt Number: _____
Cash: _____	Check: _____	Credit Card: _____