Roanoke Rapids Parks & Recreation Department **Program Registration**

All Participants:

Program Name: _____

Program Date: _____

First Name: _____

Last Name: _____

Birth Date: MO: ____ DAY ____ YEAR _____

AGE (as of today): _____

Address: _____

City: _____

State/Zip: _____

Phone #: _____

T-shirt Size (If applicable)_____

City Resident: ☐ Yes ☐ No

Sex: ☐ Male ☐ Female

Medical Information (allergies, special medications, instructions, etc.)

_____

_____

_____

_____

In case of an emergency, participants will be taken to Halifax Regional Medical Center.

EMERGENCY CARE INFORMATION:

Child's Doctor:_____

Office Phone _____

Child's Dentist _____

Office Phone _____

EMERGENCY CONTACT:

Name: _____

Phone #:_____

Phone (Work): _____

I agree that the Roanoke Rapids Recreation Department may authorize the physician of his/her choice to provide emergency medical care in the event that I nor the family physician can be contacted immediately.

PHOTO RELEASE STATEMENT:
Pictures or video clips may be taken while participating in City of Roanoke Rapids Parks and Recreation programs. If you do not concur please notify the Parks and Recreation Department at (252) 533-2847

WAIVER:
I hereby release the City of Roanoke Rapids from responsibility for injuries (physical or otherwise) incurred during program activities.

By signing you are indicating that you have read and understood all of the information above and that all of the information provided is accurate:

Signature of Participant _____ Print Name _____

Signature of Parent _____ Print Name_____
(If participant is a minor)

Fee paid: _____ Receipt #: _____

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