Program Registration Form
PH: (561) 791-4005 (Weather Updates Press: 1) **FAX** (561) 791-4009
www.wellingtonfl.gov
Follow us on Twitter @WellRecreation for updates and alerts.

PROGRAM NAME	PROGRAM CODE #	START DATE	TIME	COST

INSURANCE: The Wellington Parks and Recreation Department does not carry medical or accident insurance for program participants. I/We understand that participation can involve many RISKS and INJURIES, including, but not limited to, death, serious neck and spinal injuries and other serious injuries or impairment to the body. I/We understand that I/We are responsible for any medical bills resulting from participation in Wellington's Parks and Recreation Department contact sport and/or recreation programs. I/We understand that insurance is the patient/parent/legal guardian's responsibility. _____Initials

PARTICIPANT INFORMATION

Participant: _____ ☐ MALE ☐ FEMALE Date of Birth: _____
FIRST NAME LAST NAME MM / DD / YYYY

SPECIAL NEEDS, ALLERGIES, & IMPORTANT MEDICAL INFORMATION: _____

Has this child played/participated in **this** sport/program before? ☐ Yes ☐ No If yes, how many years: _____

Has this child played on a travel team for **this** sport? ☐ Yes ☐ No If yes, how many years: _____

HOUSEHOLD INFORMATION

MOTHER: _____
FIRST NAME LAST NAME

ADDRESS: _____
STREET

_____
CITY ZIP

IS THIS A NEW ADDRESS? ☐ YES ☐ NO

This is the: ☐ **PRIMARY** ☐ **SECONDARY** address of the **PARTICIPANT**.

Main Number: _____ Alt: _____
HOME/CELL/WORK HOME/CELL/WORK

Email: _____

FATHER: _____
FIRST NAME LAST NAME

ADDRESS: _____
STREET

_____
CITY ZIP

IS THIS A NEW ADDRESS? ☐ YES ☐ NO

This is the: ☐ **PRIMARY** ☐ **SECONDARY** address of the **PARTICIPANT**.

Main Number: _____ Alt: _____
HOME/CELL/WORK HOME/CELL/WORK

Email: _____

Emergency Contact: _____
NAME **RELATIONSHIP** **NUMBER**

ATHLETIC PROGRAMS

I would like to be a: ☐ Head Coach* ☐ Assistant Coach ☐ Sponsor ☐ Volunteer

* The total number of participants accepted is directly related to the number of volunteer coaches secured. No experience is necessary.

How did you hear about this program? ☐ Rec Guide ☐ Website ☐ Previous Participant ☐ Newspaper ☐ Flyer ☐ Friend/Relative

Transfer & Cancellation Refund Policy: A $10.00 per participant/activity administrative feel will be deducted for each transfer/refund. If you are unable to participate you must notify the office before the second activity/class to receive your refund. No refunds are issued after the 2nd Class. No refunds are available once the activity/class is over. A documented medical emergency can be considered for a refund after an activity/class has ended.

Registration Fee _____ ☐ Check # _____ ☐ Cash ☐ Visa / Mastercard / AmEx / Discover Total Paid _____ Accepted By _____

FOR FAX REGISTRATION – Visa / Mastercard / AmEx / Discover _____ **Exp. Date** _____

X _____
Printed name and Signature of card owner Date

NOTE: IF YOUR CHILD HAS A MEDICAL CONDITION, IT IS YOUR RESPONSIBILITY TO INFORM THE COACH/INSTRUCTOR. I/We understand that a true copy of the registrant's birth certificate shall be presented at the time of registration for verification of date of birth. I/We, as parents or guardians, agree to return all equipment issued or pay for the replacement thereof. I/We release from responsibility any person transporting the registrant to or from activities. I/We understand that participation can involve many RISKS and INJURIES, including, but not limited to, death, serious neck and spinal injuries and other serious injuries or impairment to the body. The Wellington Parks and Recreation Department does not carry medical or accident insurance for program participants. I/We understand that I/we are responsible for any medical bills resulting from participation in Wellington Parks and Recreation programs. I/We give consent for medical treatment at the nearest hospital, doctor or medical facility. I/We understand that insurance is the patient/parent/legal guardian's responsibility. In consideration of the permission granted by Wellington's Parks and Recreation to participate in these activities, I/we hereby release the Village of Wellington, its agents and employees, from all actions, causes of action, loss or damage, claims or demands of any kind and nature whatsoever which may arise by or in connection with participation or participation of my child/ward in activities related to Recreation Department Programs, which I, my heirs, estate, executors, administrators or assignees and for all members of my family, may have against Wellington Parks and Recreation and other above-described parties for all personal injuries known or unknown which I have incurred or may incur by participating in the program above. I/We give permission for Wellington Parks and Recreation to use the participant and photograph for publicity purposes. I/We the undersigned have read this release and understand all its terms. I/We execute it voluntarily and with full knowledge of its

X _____
Printed name and Signature of Parent(s) or Legal Guardian(s) Date

WELLINGTON PARKS & RECREATION DEPARTMENT: 11700 Pierson Rd., Wellington, FL 33414
Register by Fax with Credit Card to (561) 791-4009 or Register Online at www.wellingtonfl.gov

WELLINGTON

AUTHORIZED PICK-UP LIST

Name of camp participant (please print): _____

Attention Parent/Guardian: **Only those listed on this form will be authorized to pick up your child. Any person not listen below will be unable to pick up your child from camp.**

The camp participant lives with (check the one where the participant resides the most):

Both parents: _____ **Mother:** _____ **Father:** _____ **Guardian:** _____

Persons Authorized to Pick Up Your Child: (Please include yourselves as authorized)

Name: _____ **Name:** _____

Address: _____ **Address:** _____

City/State/Zip: _____ City/State/Zip: _____

Phone: _____ Phone: _____

Relationship: _____ Relationship: _____

Name: _____ **Name:** _____

Address: _____ **Address:** _____

City/State/Zip: _____ City/State/Zip: _____

Phone: _____ Phone: _____

Relationship: _____ Relationship: _____

Persons Who Are Absolutely NOT Allowed to Pick Up the Child:

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Why? _____ Why? _____

_____ _____

Photo ID will be required when picking up child from camp.

_____ _____

Parent/Guardian Name (printed) Parent/Guardian Signature

WELLINGTON

EMERGENCY CONTACT LIST

Name of camp participant (please print): _____

Attention Parent/Guardian: In the event that an emergency takes place at camp involving your child, we want to make sure we can reach you or someone in your family. Often, during an emergency, the lack of information or the inability to communicate with staff causes more worry than the emergency itself. Please help us avoid this by being able to reach someone in your family at all times.

Please list below emergency contacts. Please list the contacts in the order of importance. For example, the first contact listed should be the one where we are most likely to reach you or someone you can trust.

Emergency Contacts:

1st Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Relationship: _____

2nd Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Relationship: _____

3rd Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Relationship: _____

4th Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Relationship: _____

_____
Parent/Guardian Name (printed)

_____
Parent/Guardian Signature

PARTICIPANT AGREEMENT, RELEASE AND ASSUMPTION OF RISK

WAIVER – 2012

In consideration of the services of Aerial Trapeze Academy, LLC and their agents, owners, officers, volunteers, participants, employees, and all other persons or entities acting in any capacity on their behalf (hereinafter collectively referred to as ATA), I hereby agree to release, indemnify, and discharge ATA, on behalf of myself, my spouse, my children, my parents, my heirs, assigns, personal representative, and estate as follows:

1. I acknowledge that my participants in learning the trapeze art entails known and unanticipated risks that could result in physical or emotional injury, paralysis, death, or damage to myself, to property, or to third parties. I understand that such risks simply cannot be eliminated without jeopardizing the essential qualities of the activity.

The risks include, among other things: Circus activities entail certain risks that simply cannot be eliminated without jeopardizing the essential qualities of the activity. Without a certain degree of risk, circus students would not improve their skills, and the enjoyment of the activities would be diminished. Circus activities expose its participants to the usual risk of cuts and bruises. Minor rope burns might occur from falling into the net. Other more serious risks exist as well. Traveling to and from shows, meets or exhibitions, raises the possibility of any manner of transportation accidents. In any event, if you or your child is injured you and your child may require medical assistance at your at your own expense.

Furthermore, ATA employees have difficult jobs to perform. They seek safety, but they are not infallible. They might be unaware of a participant's fitness or abilities. They may misjudge the weather or other environmental conditions. They may give incomplete warnings or instructions, and the equipment being used might malfunction.

2. I expressly agree and promise to accept and assume all of the risks existing in this activity. My participation in this activity is purely voluntary, and I elect to participate in spite of the risks.

3. I hereby voluntarily release, forever discharge, and agree to indemnify and hold harmless ATA from any and all claims, demands, or causes of action, which are in any way connected with my participation in this activity or my use of ATA's equipment of facilities, **including any such claims which allege negligent acts or omissions of ATA.**

4. Should ATA or anyone acting on their behalf, be required to incur attorney's fees and costs to enforce this agreement, I agree to indemnify and hold them harmless for all such fees and costs.

5. I certify that I have adequate insurance to cover any injury or damage I may cause or suffer while participating, or else I agree to bear the cost of such injury or damage myself. I further certify that I am willing to assume the risk of any medical or physical condition I may have.

6. In the event that I file a lawsuit against ATA, I agree to do solely in the State of Florida, and I further agree that if the substantive law of Florida shall in that action without regard to the conflict of law rules of that State. I agree that if any position of this agreement is found to be void or unenforceable, the remaining document shall remain in full force and effect.

By signing this document, I acknowledge that if anyone is hurt or property is damaged during my participation in this activity, I may be found by a court of law to have waived my right to maintain a lawsuit against ATA on the basis of any claim from which I have released them herein.

I have had sufficient opportunity to read this entire document. I have read and understood it, and I agree to be bound by its terms.

Signature of Participant: _____ **Print Name:** _____

Email Address: _____

Phone: _____ **Date:** _____

PARENT OR GUARDIAN'S ADDITIONAL IDEMNIFICATION
(Must be completed for participants under the age of 18)

In consideration of _____ (print minor's name) ("Minor") being permitted by ATA to participate in its activities and to use its equipment and facilities, I further agree to indemnify and hold harmless ATA from any and all claims which are brought by, or on behalf of Minor, and which are in any way connected with such use or participation by Minor.

Parent or Guardian Signature: _____ **Date:** _____

Print Name: _____ **Email:** _____

WELLINGTON

AUTHORIZED MEDICATION FORM

Name of camp participant (please print):

_____

I, _____, as legal Parent/Guardian, hereby give permission for the above named child to receive/take medication during camp hours.

I understand that the City of Wellington, its agents or employees, undertakes no responsibility for administration of medication (any and all medication must be self-administered by the camp participant).

I agree and attest that a licensed physician has authorized any prescribed medication listed below.

I hereby release the City of Wellington and its agents and employees from any and all liability that may result in the above-named child taking medication.

Medication List

Please list below **all** the medication, both prescribed and over-the-counter, that your child is approved to take during camp hours. Please note that if a medication is not listed on this form, your child will not be allowed to take it. Please list everything, including aspirin, Tylenol, vitamins, etc.

Name of Medication	Dose Needed	# of Doses/day	When to take
Example: Amoxycilin	1 tablet	3 times per day	with meals
1.			
2.			
3.			
4.			
5.			

This form will be kept on file and reviewed each day. If any changes are needed, either additions or deletions, please contact the camp coordinator or Athletics Programs Coordinator. Please remember that your child will not be allowed to take any medication that is not listed on this form.

_____ _____ _____

Parent/Guardian Signature Telephone Date