*If you already have an account, please fill in your last name & address and then you may skip to the registration form on the back.*

|  |
| --- |
| Primary Adult Member Information |
|  |  |  |  |  |  | Male / Female |
| First Name | **Last Name** | **Date of Birth** | **Gender** (circle) |
| Residential Address | **Mailing Address** (if not the same as residential address) |
| Emergency Contact Name & Number | **Physician Name & Number** |
| Email Address |  | **Allergies & Conditions** |
|   | Home / Work / Cell |  |   | Home / Work / Cell |
| Primary Phone | **Type** |  | **Alt. Phone 1** | **Type** |
|  | Home / Work / Cell |  | Yes / No |
| Alt. Phone 2 | **Type** | **Cellphone Carrier** | **Text Alerts Opt-In** |
| Adult Member Information |
|  |  |  |  |  |  | Male / Female |
| First Name | **Last Name** | **Date of Birth** | **Gender** (circle) |
| Residential Address | **Mailing Address** (if not the same as residential address) |
| Emergency Contact Name & Number | **Physician Name & Number** |
| E-mail Address |  | **Allergies & Conditions** |
|   | Home / Work / Cell |  |   | Home / Work / Cell |
| Primary Phone | **Type** |  | **Alt. Phone 1** | **Type** |
|  | Home / Work / Cell |  | Yes / No |
| Alt. Phone 2 | **Type** | **Cellphone Carrier** | **Text Alerts Opt-In** |
| Child Member Information |
|  |  |  |  |  |  |  |  | Male / Female |
| First Name | **Last Name** | **Date of Birth** | **Grade** | **Gender** (circle) |
| Emergency Contact Name | **Emergency Contact Number** |
| Physician Name | **Physician Number** |
| Allergies & Conditions | **Primary Parent/Guardian** |
| Child Member Information |
|  |  |  |  |  |  |  |  | Male / Female |
| First Name | **Last Name** | **Date of Birth** | **Grade** | **Gender** (circle) |
| Emergency Contact Name | **Emergency Contact Number** |
| Physician Name | **Physician Number** |
| Allergies & Conditions | **Primary Parent/Guardian** |

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| Child Member Information |
|  |  |  |  |  |  |  |  | Male / Female |
| First Name | **Last Name** | **Date of Birth** | **Grade** | **Gender** (circle) |
| Emergency Contact Name | **Emergency Contact Number** |
| Physician Name | **Physician Number** |
| Allergies & Conditions | **Primary Parent/Guardian** |

REGISTRATION FORM

|  |  |  |
| --- | --- | --- |
| **MEMBER’S NAME** | **PROGRAM** | **FEE** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **Check #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cash Receipt # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **TOTAL FEES** |  |

 **DISCLAIMER**

Pembroke Recreation does not carry insurance on participants and assumes no liability for injuries sustained while participating in our program. Recreation Program participants participate in a number of competitive sports and the by signing this release I recognize and understand that injuries can occur while participating and can be an inherent and unavoidable consequence of some activities. Having read this disclaimer I hereby consent to my participation and or my child’s participation in Pembroke Recreation’s voluntary programs and agree to hold Pembroke Recreation, its commissioners, coaches, directors and managers harmless from any and all actions, claims and damages for personal injuries and disabilities that we may sustain or incur as a result of participation in this program.

|  |  |  |
| --- | --- | --- |
| Participant Signature |  | Date |
|  |  |  |
|  |  |  |
| Parent’s/Guardian’s Signature if participant is under 18 years of age |  | Date |

I understand that every effort will be made to contact the emergency contact person in case of an emergency requiring medical attention for me or my child. However, if that person cannot be reached, I hereby authorize the Pembroke Recreation Department to transport me to the nearest hospital and to secure the necessary medical treatment. By signing below I grant the Pembroke Recreation Department permission for medical emergency authorization.