

\_\_\_\_\_  
 PRINT PARTICIPANTS' NAME

**WESTMOOR PARK REGISTRATION FORM**  
 119 Flagg Road, West Hartford, CT 06117  
 Phone 232-1134, fax 236-3815

**Primary Guardian & emergency contact (Please Print)**

Last Name \_\_\_\_\_  
 First Name \_\_\_\_\_  
 Street \_\_\_\_\_  
 Town \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_ Home # \_\_\_\_\_  
 Cell # \_\_\_\_\_ Work # \_\_\_\_\_  
 Household E-mail \_\_\_\_\_

**Secondary Guardian & emergency contact (Please Print)**

Last Name \_\_\_\_\_  
 First Name \_\_\_\_\_  
 Street \_\_\_\_\_  
 Town \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_ Home # \_\_\_\_\_  
 Cell # \_\_\_\_\_ Work # \_\_\_\_\_  
 Household E-mail \_\_\_\_\_

Additional Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_

Emergency Phone # Home \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Participant (Please Print) Full Name \_\_\_\_\_

PROGRAM #	TITLE	DAY(S)	TIME	BEGINS	ENDS	FEE
<b>TOTAL</b>						

Has participant been prescribed an epi-pen? No\_\_ \* Yes\_\_ Explain: \_\_\_\_\_

**\*If YES,** and the epi-pen will be with the child, an additional form is required to be signed by the parent and the prescribing physician.

List any allergies, illnesses, disabilities, physical limitations, special needs, etc of participant: \_\_\_\_\_

List any medications: \_\_\_\_\_

Family Doctor's Name: \_\_\_\_\_ Doctor's Phone: \_\_\_\_\_

**For "CAMP" programs; Please read each statement below and if you understand and agree to each statement WRITE YOUR INITIALS in the space next to the paragraph to signify your understanding and agreement.**

\_\_\_\_\_ In the event my child needs emergency hospital or medical care while participating in this West Hartford Leisure Services Program and there is no time for me to be contacted and/or I cannot be reached, my hospital preference is:

**Hospital Name and Address:** \_\_\_\_\_

\_\_\_\_\_ However, if circumstances are such that it is deemed necessary to admit elsewhere, permission is hereby granted.

\_\_\_\_\_ In the event my child needs emergency medical care while in this West Hartford Leisure Services Program, I hereby give permission for the hospital to give such emergency treatment as is considered necessary or desirable by medical judgment, including administration of anesthesia.

\_\_\_\_\_ In the event that my child needs to be transported by an ambulance, I give my permission for such transportation and I agree to assume all expenses incurred by said transportation.

\_\_\_\_\_ I agree to assume all medical expenses incurred by my child while participating in this West Hartford Leisure Services Program.

\_\_\_\_\_ **FIELD TRIPS:** I hereby give my permission for my child to go on the field trips scheduled for his/her particular camp program. The exact schedule will be provided to me at the beginning of the camp session. If I do not wish my child to attend the field trip, I understand that I will need to make other arrangements for my child on that day.

I realize that as with any physical activity there is a possible risk of accidental injury to my child while participating in this West Hartford Leisure Services Program. I agree to assume the risk of any injury which my child might suffer while involved in the West Hartford Leisure Services Program and will not hold the Town of West Hartford or its instructors liable for any injuries which my child may suffer while participating in this West Hartford Leisure Services Program.

**PAYMENT TYPE:** Cash (in person only) \_\_\_\_\_ Check (payable to "Westmoor Park" ) Check # \_\_\_\_\_

Visa  Master Card Credit card number --- Expiration Date:

Signature \_\_\_\_\_

Date \_\_\_\_\_