

# Town of Arlington

## Parks and Recreation



The Age cut-off date is August 15<sup>th</sup> of each calendar year. If the child's birthday falls on August 15<sup>th</sup>, the child will move up to next age group.

Participant's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

CIRCLE: MALE FEMALE Grade: \_\_\_\_\_ School Child Attends: \_\_\_\_\_

Full Address: \_\_\_\_\_

Mother/Guardian: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Father/Guardian: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Primary E-Mail address: \_\_\_\_\_

Emergency Contact: (Must be someone other than Legal Guardians)

\_\_\_\_\_ Phone Number: \_\_\_\_\_

Shirt Size:

Short Size:

Youth: S (6-8) M (10-12) L (14-16)

Youth: S (6-8) M (10-12) L (14-16)

Adult: S M L XL XXL

Adult: S M L XL XXL

### Forms Needed for Registration

- **Birth Certificate of Child Participating**
- **Proof of Insurance**
- **Proof of Residency: Parents/Guardians must provide TWO of the following items showing the Parent/Guardian's name and address to prove residency.**

- Most recent MLGW Bill**
- Municipal Water Bill**
- Cable Bill**
- Phone Bill**
- Real Estate Tax Receipt**
- Mortgage Statement**
- Rental Agreement**
- Copy of Valid Driver's License**

**Assumption of Risk:** I acknowledge and understand that there is a risk of injury involved in participation. I understand that my child will be under the supervision and direction of a Town of Arlington volunteer coach. I agree to follow the rules for the sport and the instructions of the coach to reduce the risk of injury to my child and others. I freely, knowingly, and willfully accept and assume the risk of injury that might occur from my child's participation in youth athletics. **Initial:** \_\_\_\_\_

**Release:** In consideration of the Town of Arlington allowing my child to participate in youth athletics, I hereby agree to release, waive, discharge, covenant, not to sue, hold harmless, and indemnify, for myself, my family, my estate, my heirs, my administrators, my executors, my assignees, and my successors, the Town of Arlington its trustees, officers, agents, servants, representatives, employees, successors and assigns, including the Town's athletic staff, coaches, assistant coaches, and athletic trainers from liability to us and our child, for any and all claims, suits and causes of action arising from or out of any injury, known or unknown, to property or body, that my child may suffer from participation in Town of Arlington athletics, activities, or the above-described sports activities.

**Initial:** \_\_\_\_\_

**Photographs:** Photographs will occasionally be taken of the children during the sports activities. By signing this registration form, I consent to the use of pictures of my child for displays, brochures, and promotional materials with no compensation to me or my child. **Initial:** \_\_\_\_\_

**Certification of Child's Fitness and Medical Authorization:** I, the undersigned, hereby certify that my child is physically able to safely participate in the sports activity for which they have been registered. In addition, I understand that in the case of the illness or injury, the Town of Arlington will try to notify me or the emergency contact listed. In the event that neither I nor the emergency contact person can be notified, I hereby authorize the Town of Arlington officials or my child's coach to obtain the necessary medical care and/or treatment for my child, and I hereby accept the sole financial responsibility for medical care, first aid or treatment.

**Initial:** \_\_\_\_\_

**Name of Insurance Company:** \_\_\_\_\_ **Insurance Policy Number:** \_\_\_\_\_

Please list any conditions, concerns or needs that you feel our staff should know. This is important for the safety of your child. \_\_\_\_\_

The number of teams is determined by the number of coaches that volunteer. Please note your willingness to volunteer by circling one or more of the following:

Head Coach      Assistant Coach      Sponsor

\*All volunteers are subject to a full background check.

**Refund Policy:** Refunds will not made unless due to medical reasons. Medical refunds must be accompanied by a doctor's recommendation.

I represent that I am a parent or legal guardian of the child or ward listed above, and that I am duly authorized to execute this release and waiver on his/her behalf. By signing below, I acknowledge that I have read this document and understand it.

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

For Office Use Only:

Date: \_\_\_\_\_ Receipt #: \_\_\_\_\_ Amount Paid: \_\_\_\_\_ Check #: \_\_\_\_\_ Registered By: \_\_\_\_\_