



**TOWN OF
HOPKINTON
Parks & Recreation
Department**

**330 Main St., Hopkinton NH 03229
603-746-2915 / FAX: 603-746-2952
parkrec@tds.net www.hopkinton-nh.gov**

PROGRAM REGISTRATION FORM

PROGRAM NAME _____

PARTICIPANT INFORMATION *(Please Print)*

Name _____ M / F

Date of Birth _____ Age _____ Grade _____

Address _____

Email (please print) _____

May we add your email to the Recreation Department Email list? Yes No

Phone (Hm) _____ (Wk) _____ (Cell) _____

PARENTS / LEGAL GUARDIANS *(If participant is under 18 years of age)*

Name: _____

Address _____

Email (please print) _____

May we add your email to the Recreation Department Email list? Yes No

Phone (Hm) _____ (Wk) _____ (Cell) _____

PICK-UP LIST ONLY names listed on this form are permitted to pick up the participant listed above.

Name _____ Relationship _____ # _____

Name _____ Relationship _____ # _____

ALTERNATE EMERGENCY CONTACT:

Name _____ Relationship _____ # _____

Name _____ Relationship _____ # _____

PROGRAM SPECIFIC DETAILS

If the program in which you are registering for has options, please make note of your selections below. For example, session number, chosen time, or shirt size. Please refer to the program description to determine if you need to make notes:



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PHOTO RELEASE

I hereby grant the Town of Hopkinton permission to use my child's photograph, video picture, and/or other digital reproduction of him/her or other reproduction of his/her physical likeness for publication processes, whether electronic, print, digital or electronic publishing via the Internet or other Recreation Department materials. Please Check: Accept Decline

WAIVER AND RELEASE OF LIABILITIES

Participation in the Program Named Above may involve risk of injury, which may include, but is not limited to falls, sprains, bruises, insect bites, torn muscles, broken bones, eye/head injuries, and/or death. As a parent or guardian, or as a willing participant, I attest and verify that I have full knowledge of all risks involved and that my child/self is physically fit to participate in the Program Named Above. I hereby for myself, my heirs, executors, and administrators waive and release all rights and claims against the Town of Hopkinton, its officers, agents, employees, and volunteers, except in the case of their sole negligence, from all losses, injury, damages, fees, and other expenses arising out of or in connection with participation. In addition, in case of emergency, I hereby give permission to the Hopkinton Parks & Recreation to obtain qualified medical personnel, to securing proper medical treatment for my child or self. I understand that this may include hospitalization, routine tests, X-rays and/or other medical treatment for which any fees incurred will be my responsibility.

PARTICIPANT SIGNATURE _____ DATE _____

PARTICIPANT PRINTED NAME _____

PARENT/GUARDIAN SIGNATURE _____ DATE _____

PARENT/GUARDIAN PRINTED NAME _____

PAYMENT

Registration forms are only accepted with payment in full unless otherwise indicated on the program's description. Checks may be made payable to the Town of Hopkinton and mailed or dropped off at the Town Hall or Slusser Senior Center. The Hopkinton Recreation Dept.'s office is located in the Slusser Senior Center. Please call or email the Recreation Department with any questions.

OFFICE USE:

Program Fee _____

Amt. Paid _____ Amt. Due _____

Check #/Cash _____

Date _____

Rcvd. By: _____



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PARTICIPANT'S HEALTH RECORD

The following information is to be completed by the parent/legal guardian. It will be held confidential and will be only used to benefit the participant. PLEASE PRINT, USE BACK IF NEEDED, SIGN and DATE.

PHYSICIAN NAME _____ PHONE _____

HOSPITAL _____ ADDRESS _____

Are there any concerns with the participant's ability to adapt to a camp/group setting?
(.i.e., physical handicap, sensory problems or loss, developmental irregularities)

Is the participant currently taking any medications that we should be aware of?

Does the participant have allergies, such as to food, animals, or any medications?

Does the participant have any hospitalizations, operations, reoccurring illnesses, or any other health concerns of which the program staff should be aware of?

Are there any other concerns about the participant that should be made known?

"The above information is true and complete to the best of my knowledge."

PARTICIPANT SIGNATURE _____ DATE _____

PARTICIPANT PRINTED NAME _____

PARENT/GUARDIAN SIGNATURE _____ DATE _____

PARENT/GUARDIAN PRINTED NAME _____