

REGISTRATION FORM

Receipt #: _____

Information: 626-569-2160 • Fax: 626-569-2240 • www.cityofrosemead.org

Adult/Parent/Legal Guardian Contact:

First Name: _____ Last Name: _____

Address: _____ City: _____ Zip Code: _____

Cell Phone: _____ Email: _____

Emergency Contact: _____ Relationship: _____

Emergency Phone Number: _____

Participant Names (First and Last)	DOB	Activity Name	Session/Day	Time	Fee
					\$
					\$
					\$
					\$
					\$

RELEASE OF LIABILITY, HOLD HARMLESS, AND AGREEMENT NOT TO SUE:

I _____, as an adult participant or parent/guardian of above named minor participant(s), hereby expressly and irrevocably consents to my/minor's participation (all uses of "I" or "me" herein are made on behalf of both the minor and the parent or guardian), fully understand that my participation in the above activity exposes me to the risk of personal injury, death, or property damage. I understand that there are risks inherent in such activity and hereby acknowledge that I am voluntarily participating in this activity and agree to assume any such risks.

In consideration for being permitted to participate in this activity I hereby release, discharge, and agree for myself, my heirs, administrators, executors and assigns not to sue the **City of Rosemead, its employees, and/or Contracted Instructor** for any injury, death, or damage to or loss of personal property arising out of, or in connection with, my participation in the activity from whatever cause. I further agree to indemnify and hold harmless the **City of Rosemead, its employees, and/or Contracted Instructor** from any and all claims, demands, actions, or suits arising out of, or in connection, with my participation in the activity.

In case of accident or other emergency, I hereby authorize personnel or volunteers of the City of Rosemead or agents of the City to secure medical care deemed necessary as a result of accident or injury of me. In the event of illness or injury, I hereby consent to whatever x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care considered necessary in the best judgment of the attending physician, surgeon or dentist, and performed by or under the supervision of a member of the medical staff or the hospital furnishing medical or dental services.

I also permit the use of activity/event photography and/or video of my child or myself for media promotion.

I HAVE CAREFULLY READ THIS RELEASE OF LIABILITY, HOLD HARMLESS, AND AGREEMENT NOT TO SUE, AND I FULLY UNDERSTAND ITS CONTENTS. I AM AWARE THAT IT IS A FULL RELEASE OF ALL LIABILITY AND SIGN IT OF MY OWN FREE WILL.

Resident Non-Resident

Cash Check # _____ CC# (Last 4 Digits) _____ Total paid \$ _____

Signature: _____ Date: _____ Parent/Guardian Participant

