RECREATION YOUTH FIELD HOCKEY – 2017

Please return completed form along with payment to the Waldoboro Town Office or mail to: Waldoboro Recreation Department, P. O. Box J, Waldoboro, ME 04572 **Waldoboro residents: $25.00**
(Please make checks payable to: Town of Waldoboro) **Non-residents: $35.00**

Name:_____ Age:____ Date of Birth:_____ Grade:_____ Height_____

Address:_____ Town:_____ Home #: _____

School:_____ Parent's e-mail address: _____
Parent (1) /Guardian:_____ Home #: _____ Work/Cell_____
Parent (2) /Guardian:_____ Home #: _____ Work/Cell_____
Emergency Contact: _____ Home #: _____ Work/Cell_____
Doctor's Name:_____ Tel #:_____ Hospital:_____
Allergies or special medical conditions:_____

Shirt Size (circle one): (youth) S 6-8 M 10-12 L 14-16 XL 18-20 (adult) S 34-36 M 38-40 L 42-44 XL 46-48 XXL 50-52

(please be sure to order the correct shirt size, organizers are not responsible if the shirt does not fit properly)

Volunteer Support: I would be interested in: _____ being a Head Coach _____ being an Asst. Coach

_____ helping with fundraising _____ being a volunteer referee .

SPORTSMANSHIP: As a Spectator, I will encourage good sportsmanship by demonstrating positive support for all players, coaches and officials at every game and practice. I will remember that this is a children's program and Coaches are volunteers. I will show support for my child's accomplishments and I will never cheer another child's failure. _____ ***Parent's initials***

LIABILITY RELEASE: I agree to waive and release any and all claims I may have against Town of Waldoboro and MSAD 40 including their agents, employees, paid and non-paid volunteers, officers, chaperones, leaders, organizers and sponsors.

MEDICAL TREATMENT: I understand that although a physician's examination is not required for registration, it is highly advisable that participants consult with a physician before participation in athletic and strenuous activities. Medical insurance is not provided. In the event that my child becomes ill or is injured, I hereby authorize whatever medical care and/or services necessary under the circumstances to preserve life, limb or the well being of my dependent. I understand that the program will attempt to notify me as soon as possible.

PHOTO RELEASE: I authorize the release of any photographs taken of my child as part the program to be published in the newspaper or posted on the internet. ***Parents initials*** _____.

I have read this form and understand its content. The person named herein has been granted permission to participate in the Waldoboro Recreation Youth Program listed above.

_____ _____ _____
Signature Parent/Legal Guardian (printed name) Date

PRIVACY POLICY - Identifiable Personal Information is information about a natural person that is readily identifiable to that specific individual. Information collected on this form will be used solely for registration in a program. We will not release or share information with other agencies or entities that is not required by 1 M.R.S.A. Chapter 13.

For office use only:
Payment type: check cash Amt Rcvd: _____ Check # _____ Pmt received by:_____ Date:_____