



Hallett Center of Crosby Registration Form and Waiver

Information

Participant Name _____ Male ___ Female ___ DOB ___/___/___

Allergies/Special Conditions _____ Shirt Size _____

Main Contact _____ Hallett Center of Crosby Member ___Yes ___No

First Name _____ Last Name _____

Mailing Address _____ City _____ State _____ Zip _____

Phone _____ Email _____

Emergency Contact & Phone _____

Program Registration

Program	Level/Grade	Amount Paid
Total:		

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Liability Release

Please read this form and be aware that in attending the Hallett Center of Crosby and participating in the selected activity, along with using the facility equipment, you will be assuming the risk, legal liability, and waiving and releasing all claims for injuries, damages or loss which you might sustain as a result of participating in any and all activities connected with and associated with the Hallett Center. The Hallett Center of Crosby shall not be liable for any damages arising from personal injuries sustained in, on or about the premises of the facility, and does hereby fully and forever release and discharge the health fitness centers, owners, management company, and employees, from any action of cause of action present or future, whether the same be known or unknown, anticipated or unanticipated, resulting from or arising out of the Hallett Center of the facilities and equipment. Participants registering hereby permit the taking of photos, audio, and videotape during the Hallett Center of Crosby activities for publication and use as the facility seems appropriate.

Emergency Medical Authorization

I give the Hallett Center of Crosby permission for my child to be given cardiopulmonary resuscitation (CPR) and first aid treatment by a certified staff member of the Hallett Center. I also give permission for my child to be transported by ambulance to an emergency center for treatment. I authorize the Hallett Center to obtain immediate medical care and give consent to the hospitalization and performance of necessary diagnostic tests upon, the use of surgery on, and/or the administration of drugs to my child or ward if an emergency occurs when I cannot be located immediately. It is also understood that this agreement may only cover those situations which are true emergencies and only when I cannot be reached. I understand that the provider will take every effort to contact me and/or my designated emergency contacts. I will be responsible for payment of medical expenses.

X _____
Signature of Parent or Guardian Date

Payment Received \$ _____

Date Received _____

Staff Initials _____