Hallett Center of Crosby
Registration Form and Waiver

Information

Participant Name ______________________________ Male____ Female____ DOB___/___/___Age______

Allergies/Special Conditions____Shirt Size____

Main Contact Hallett Center of Crosby Member __Yes __No

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.

Additional Person(s) Authorized To Pick Up Your Child

***Your child will not be released to anyone else unless permission is given in writing by you, adults picking up your child may need to show a Photo ID)*

Name____Phone__________________

Name____Phone__________________

X____

Signature of Parent or Guardian Date

Payment Received $_______ **Date Received___________** **Staff Inititials_______**