Hallett Center of Crosby
Registration Form and Waiver

Information

Participant Name ______________________________________Male____ Female____ DOB___/___/___Age________

Allergies/Special Conditions____Shirt Size________

Main Contact Is the Parent/Guardian a Hallett Center of Crosby Member __Yes __No

Name____

Mailing Address______________________________________ City____________________ State_____ Zip____________

Phone______________________ Email____

Emergency Contact & Phone____

Program Registration

Program	Age/Level	Amount Paid
		Total:

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Liability Release

I acknowledge and understand that participating in the selected activity and using the Hallett Center equipment creates a risk of injury for my child. In consideration for participating, I agree to defend and indemnify the Hallett Center, its employees and agents from all claims for damages arising out of my child's use of Hallett Center and his/her participation in Hallett Center programs. I further waive all claims against the Hallett Center, its employees and agents for cause of action present or future, whether the same be known or unknown, anticipated or unanticipated, resulting from or arising out of the use of Hallett Center 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 Initials**_______