



Arbuckle Parks & Recreation District

TBALL CLINIC — Registration Form

Name _____ Age _____ Date of Birth _____

School _____ Grade _____ Gender: Male Female

Shirt Youth Size: XS S M L X-L

Father Name _____ Mother Name _____

Home Phone _____ Work/Cell Phone(s) _____

Address _____

Email _____ Email _____

EMERGENCY CONTACT INFORMATION

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

MEDICAL INFORMATION

Health Insurance Company _____

Family Physician _____ Address _____ Phone _____

I hereby certify that the above named child is in normal health and is capable of participating safely. I understand that Participants agree to release all liability and hold the Arbuckle Parks and Recreation District harmless. I give my permission for the above child to participate. I give consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. I understand that my child participates at his/her own risk.

Parent/Guardian Signature _____

PHOTO RELEASE: I hereby give my consent to ARPD to post photographic images of my child for the purpose of acknowledging awards, community recognition and publicity on the APRD's website and APRD's Facebook account. I understand that no other personal identifiable information about my child will be published with the photograph.

Parent/Guardian Signature _____

Please make checks payable to: Arbuckle Parks and Recreation District or APRD. Late Fee of \$15 per child will be added to standard fee for registrations forms received after sign ups dates. **Refunds** after program begins are given at the discretion of the program supervisor. There are no make-ups unless something unexpected occurs with the facility or the instructor.

Fee: **Per Child - \$70**

Fee _____ Method of Payment _____ Receipt # _____