

REGISTRATION FORM

PARTICIPANT'S NAME: _____ BIRTH DATE: _____ AGE: _____ GENDER: _____

Last First

ADDRESS: _____ CITY: _____ ZIP: _____

PH#: _____ WORK PH#: _____ EMAIL: _____

GRADE: _____ SCHOOL: _____ PARENTS NAME: _____

SECONDARY CONTACT: _____ SECONDARY PHONE: _____

PROGRAM NAME	DIVISION	COURSE #	DATE OF CLASS	TIME	FEE
Voluntary Scholarship Donation:					TOTAL

YOUTH SPORTS ONLY

Please complete the following information to help balance teams. PLAYER REQUESTS WILL NOT BE TAKEN. Thank You.

Height: Weight: # of seasons previously played in this sport:

T-Shirt Size: (Please circle) YXS - YS - YM - YL - AS - AM - AL - AXL
 Sizes (2-4) (6-8) (10-12) (14-16)

I am interested in coaching or asst. coaching — Name _____ Contact #: _____

I am interested in sponsoring a team — Name of Business _____

Medical Conditions: _____

WE ACCEPT CASH, CHECK, AND CREDIT/DEBIT CARD. MAKE CHECKS PAYABLE TO: CITY OF POST FALLS

CREDIT CARD PAYMENT

___Master Card ___Visa Card # _____ Exp. Date: _____ CVV# _____

Please note: A convenience fee will be charged on all debit/credit cards.

WAIVER AGREEMENT

I hereby agree to participate (or allow my child to participate) in the above-named program, which is a recreational or educational activity to be conducted by the city of Post Falls, and do hereby acknowledge that such participation presents risks, some of which are unknown. I agree to assume all risks associated with such participation. I do, on behalf of my child/ward and any persons who may have an interest in his/her well-being or property, hereby release and forever discharge the City of Post Falls, Idaho, its agents, servants, employees and cooperators from any and all real possible claims for damages or other harm to person or property, regardless of the manner by which any such claim may be brought. I accept the terms of this complete and total release and agree to be bound by it of my own free will. I understand that the Post Falls Parks & Recreation Department may use mine or my child's picture for promotional purposes.

I hereby consent to first aid, emergency medical care, and authorize, if necessary, admission to a hospital for treatment of injuries that myself or my child/ward could sustain while participating in this program. I understand that I am responsible for any and all medical expenses which may be incurred as a result of any accident or illness while participating in the program.

I AM THE PARENT OR LEGAL GUARDIAN, OF THE ABOVE-NAMED PARTICIPANT, WHO IS REFERRED TO IN THIS AGREEMENT AS BY CHILD/WARD. MY APPROVAL OF THIS AGREEMENT MEANS THAT I CANNOT LATER BRING A CLAIM FOR DAMAGES AGAINST THE CITY OF POST FALLS AND ANY COOPERATORS IN THIS PROGRAM. (A \$20.00 fee will be charged on all NSF checks.)

SIGNATURE OF PARENT/LEGAL GUARDIAN, OR PARTICIPANT (IF OVER 18) _____ DATE _____