**Sullivan Parks & Recreation Department/Sullivan Community Council 707 Legion Drive, Chittenango, NY 13037**
**https://sullivan.recdesk.com 315-687-3471**

# YOUTH & ADULT REGISTRATION FORM

**ADULT PARTICIPANT-PARENT/GUARDIAN INFORMATION**

**Name**_____ **Phone (Cell)**_____ **(Home)**_____ **(Work)**_____

**Name**_____ **Phone (Cell)**_____ **(Home)**_____ **(Work)**_____

**Address** _____ **City** _____ **State** _____ **Zip:**_____

**E-mail Address(s)**_____

| Emergency Contact Name-(NOT in same household) | Phone Number | Relationship |
|---|---|---|
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**Would you be interested in volunteering or coaching?**_____ **Are you a Town of Sullivan Resident?**_____

**T-SHIRT SIZES ARE – YM; YL; AS; AM; AL; AXL; AXXL**

| Participant Name (Youth or Adult) | Birthdate | Grade (Youth only) | Shirt Size | Program Name | Session Date | Fee |
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| Name of Authorized Person (In addition to Parents) to Pick Up Child | Phone Number | Relationship |
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***Release of Minors:*** *I, the undersigned, give complete permission to the below named person(s) to participate in the Town of Sullivan/SCC program listed below, and certify that all information on this form is complete and accurate. As the parent/guardian of the below named minor(s), I hereby give my consent for emergency medical care prescribed by a duly licensed Doctor of Medicine. This care may be given under whatever conditions are necessary to preserve the life, limb or well-being of my dependent.*

***Adult Program Release:*** *I hereby certify with my signature below that I will accept full responsibility and intend to be legally bound hereby, for myself, my heirs, executors and administrators, waive and release any and all claims for damages I may have against the Town of Sullivan, Sullivan Community Council, Chittenango Central School District, volunteers, employees, building supervisors, program supervisors, assignees and agents for all injuries suffered by me in said program. I acknowledge that the Town of Sullivan Parks & Recreation Dept. strongly recommends that I have a complete physical examination (at my own expense) to determine my fitness to participate and I assume full responsibility for possible consequences if this is or is not done. I also attest and verify that I am physically fit to participate in the below named program.*

**Statement of current medical conditions, allergies or medications:**_____

**Do you need special accommodations?**_____

**Photographs may be taken of recreation programs and used for marketing purposes. Initial if you do NOT authorize:**_____

REFUND POLICY No refunds will be given if requested after the program start date. If a refund is requested before the program start date, the refund amount will prorated depending on how much cost has already been incurred to the program.
**Convenience/processing fees associated with credit card payments cannot be refunded, even if a program is cancelled by the department.**

**SIGNATURE:**_____ **DATE:**_____

OFFICE USE ONLY: Amount Collected:_____ Method of Payment: cash check credit card Staff Initials:_____

CREDIT CARD INFORMATION: ***All credit card transactions will be charged a 3%, plus $0.30 convenience fee. This fee is not refundable, even if a program is cancelled by the department.**

Name on Card:_____ Billing Zip Code:_____

Card Number:_____ Exp. Date:_____ Sec Code:_____