

# Program Registration Form

## Wisconsin Rapids Parks & Recreation Department

444 West Grand Avenue, Wisconsin Rapids, WI 54495 / (715) 421-8240 / [parks.wirapids.org](http://parks.wirapids.org) / Email: [parksdepartment@wirapids.org](mailto:parksdepartment@wirapids.org)

Parent's Name \_\_\_\_\_ Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Email Address: \_\_\_\_\_ (For Parks & Recreation Department use only.)

Reside In:  City of Wisconsin Rapids  Non-Resident (Outside of Wisconsin Rapids City limits)

Participant's Name	Age	Gender	Birth Date	Program Name/Activity Date(s)	Fee

*Return completed form with payment. Make Checks Payable to City of Wisconsin Rapids*

### Waiver, Release, Consent to Treatment, Use of Photographs

I, as an adult participant or as the legal guardian or parent of the minor child participant named above (hereinafter both adult and minor participants called "Participant"), recognize and acknowledge that there are certain risks of serious injury, death and property damage. Knowing all of these risks, I agree to allow participation in this program and assume the full risk of any injuries, damage or loss which the Participant may sustain as a result of participating in any and all activities connected with or associated with this program. In consideration of participation in this event, I, individually and on behalf of any minor Participant named above, voluntarily release and discharge, indemnify and hold harmless, the City of Wisconsin Rapids, (its elected officials, commissions and commissioners, officers, employees, volunteers and agents), from any and all claims, liability, cost and expense, arising out of or connected to participation in this event. This waiver and release is binding on the Participant's heirs, dependents, executors, administrators and assigns.

In the event of an emergency, I consent and authorize medical treatment deemed necessary for the Participant's immediate care and agree that I will be responsible for payment of any and all medical services rendered.

I understand that photographs or videos may be taken of the Participant during the program. I allow the Participant's image to be used in published materials and websites that promote the City of Wisconsin Rapids Parks and Recreation Department, and I agree that I will not receive compensation for use of these photographs or videos. In the event I do not wish to have the Participant's image used, I will notify the City at registration for the program.

**WIAA Concussion Policy:** As a Parent and Athlete, it is important to recognize the signs, symptoms and behaviors of a concussion. By signing this form you are stating that you understand the importance of recognizing these signs, symptoms and behaviors of a concussion or head injury. More information is available in the office and online.

Signature \_\_\_\_\_

Date: \_\_\_\_\_