HUNTERDON COUNTY DIVISION OF PARKS AND RECREATION
PROGRAM REGISTRATION FORM

Office Location: 1020 State Route 31, Lebanon
Mailing Address: PO Box 2900, Flemington, New Jersey 08822-2900
Phone: (908) 782-1158 * Fax: (908) 806-4057

PARTICIPANT(S)_____

ADDRESS_____

PHONE (day)_____(eve)_____(cell) _____

EMAIL ADDRESS _____ ☐ CHECK TO BE ADDED TO OUR E-MAIL LIST

EMERGENCY CONTACT_____PHONE (day)_____(eve/cell)_____
(other than parent or guardian)

PROGRAM:_____DATE:_____LOCATION_____TIME:_____ FEE:_____

PROGRAM:_____DATE:_____LOCATION_____TIME:_____ FEE:_____

PROGRAM:_____DATE:_____LOCATION_____TIME:_____ FEE:_____

PROGRAM:_____DATE:_____LOCATION_____TIME:_____ FEE:_____

PROGRAM:_____DATE:_____LOCATION_____TIME:_____ FEE:_____

TOTAL FEE $_____Make check payable to "Hunterdon County Parks". Fees are used to offset the cost of the program.

Requests for refunds must be made in writing and are subject to a 30% service charge. Cancellations made less than one week prior to program will NOT receive a refund.

NOTES:_____

IF THE PARTICIPANT IS UNDER 18 PLEASE PROVIDE: NAME_____ AGE_____GRADE_____

DATE OF LAST TETANUS SHOT_____ NAME_____ AGE_____GRADE_____

NAME OF PARENT OR GUARDIAN (PLEASE PRINT):

IMPORTANT—PLEASE READ THE FOLLOWING STATEMENT:
I hereby waive and release all rights and claims for damages against the County of Hunterdon and their employees and agents for all injuries, which may be sustained, by the herein named minor or myself while participating in the program listed above. I understand the content of the program and the risks of personal injury therein. I also give my permission for employees of the County and the Hunterdon Medical Center (or closest medical facility to the activity site) to admit me or my child for EMERGENCY medical treatment that would become necessary as a result of a medical emergency during this program. I also give permission to the County to make noncommercial use of any activity photographs of my child or myself. Any information provided will be treated with confidentiality and will allow the County to better serve individuals attending programs.

ACCESSIBILITY STATEMENT: It is the policy of the County to provide reasonable accommodations to persons with disabilities upon advance notice of need. Persons requiring accommodations should make request at least 2 weeks prior to program attendance.

You may withhold this data, but you might not receive appropriate accommodations, without advanced notice.

DOES PARTICIPANT TAKE ANY MEDICATION (S) Yes____ No_____ If so, what? _____

DOES PARTICIPANT HAVE ANY MEDICAL CONDITIONS OF WHICH THE STAFF SHOULD BE AWARE?
(Please Circle: Attention Deficit/Hyperactivity Disorder, Epilepsy, Diabetes, Asthma, Dietary Restrictions, Oppositional Defiant Disorder, etc.)
Yes_____ No_____ Other_____

DOES PARTICIPANT REQUIRE ANY ACCOMMODATION FOR A DISABILITY? Yes_____ No_____

DOES PARTICIPANT HAVE ANY ALLERGIES? Yes____ No_____ If so, please explain_____

DOES PARTICIPANT CARRY AN EpiPen? Yes_____ No_____

NOTES:

SIGNATURE OF PARTICIPANT(S)_____DATE_____
(Parent/Guardian if under 18 yrs. of age)

White & Canary – Office Copies Pink – Customer Copy