

# SUGAR HILL PARKS & RECREATION REGISTRATION FORM

Participant's Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Male/Female (please circle one)  
 Mother's Name \_\_\_\_\_ Work Phone \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Father's Name \_\_\_\_\_ Work Phone \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Address \_\_\_\_\_ Sugar Hill Resident Yes / No  
 City \_\_\_\_\_ Zip \_\_\_\_\_  
 E-mail Address \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

### WAIVER

I, the undersigned, assume all risks and hazards incidental to participation, including transportation to and from these activities and do hereby, for myself, my child, my heir, executors, and administrators, waive, release, absolve, indemnify and agree to hold harmless the City of Sugar Hill, Sugar Hill Parks and Recreation Department and its representatives, sponsors, affiliated associations, organizers, officers, officials and participants for any and all damages suffered by myself or my child in connection with this activity. Also, I agree that I will abide by all the rules and policies outlined in the National Rules and set by the Sugar Hill Parks and Recreation Department.

I, the undersigned, give permission to the Sugar Hill Parks and Recreation Department to photograph and video programs/activities and use those materials in advertising, promoting and reporting Parks and Recreation programs and activities.

I, the undersigned, give permission to the Sugar Hill Parks and Recreation Department to obtain and authorize medical care for said minor child at any hospital, emergency medical center, or any other health facility: by any medical doctor, osteopath, nurse, surgeon or any other medical practitioner. The undersigned further agrees to be responsible for the expenses of any medical care needed by the minor child, and hold the staff authorizing the medical care harmless from any damages suffered by the minor child or the undersigned as a result of the medical treatment authorized.

Signature (Participant/Parent/Guardian) \_\_\_\_\_ Date \_\_\_\_\_

Please list and **medical conditions** that may impact ability to participate in class/program:

### REFUND POLICY

**Participants enrolled in any class, camp or activity that is cancelled by SHPR, will be refunded their registration in FULL. Customer cancellation of classes & programs requires 48 hours notice (2-week notice for Camps) in order to receive a full refund. Please allow a minimum of 3 weeks for refund processing.**

| Class        | Day | Dates | Time | Location | Fee |
|--------------|-----|-------|------|----------|-----|
|              |     |       |      |          |     |
|              |     |       |      |          |     |
|              |     |       |      |          |     |
|              |     |       |      |          |     |
| <b>TOTAL</b> |     |       |      |          |     |

### PAYMENT

Credit Card    VISA \_\_\_\_\_ MC \_\_\_\_\_    Check # \_\_\_\_\_    Money Order \_\_\_\_\_  
 Card Number \_\_\_\_\_    Expiration Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Name as it appears on Card \_\_\_\_\_    Signature \_\_\_\_\_    Date \_\_\_\_\_

**Make Checks payable & Mail to – City of Sugar Hill / 4988 West Broad Street / Sugar Hill, GA 30518**

**Fax form with Credit Card Payment and Signature to – 770-945-0281**

**For questions regarding any programs please call 770-831-7413**