Office use: HH# ________

Wethersfield Parks & Recreation Department

505 Silas Deane Highway, Wethersfield, CT 06109 Phone: (860) 721-2890 wethersfieldct.gov/recreation

Program Registration Form

HOUSEHOLD CONTACT INFORMATION – PLEASE FILL OUT COMPLETELY

Adult First Name ______________________________ Last Name _________________________________

Adult First Name ______________________________Last Name _________________________________

Street Address ________________________________ City ___________________ State ____ Zip ______

Home Phone __________________________________ Cell Phone ________________________________

Work Phone __________________________________ Email Address ______________________________

Emergency Contact _____________________ Relationship ________________ Phone _____________

PROGRAM REGISTRATION

Participant	M/F	DOB	Grade	Program Name	Program Code	Fee

Special Information (allergies, medical conditions, medications, etc._________________________________

POOL PASS Individual Pass - $40 Family Pass - $65 (Limited to 2 adults and the children living in household)

Individual Pass - First & Last Name	Age	DOB

	Family Pass - Name	Age	DOB	Family Pass - Name	Age	DOB
Adult 1						
Adult 2						

WAIVER - READ CAREFULLY AND SIGN BELOW

I acknowledge there are certain risks in participating in a recreational activity and agree to assume the risk of injury which I and/or my child may encounter. I grant permission to seek emergency, medical care on behalf of myself and/or child. (Medical approval is suggested for those participating in any exercise class.) I further agree I will not hold employees of the Town of Wethersfield or its agents liable for any injuries which I and/or my child may encounter. I grant permission for transportation in authorized vehicles for Parks & Recreation activities and for photographs to be taken for department publicity unless otherwise noted in writing. In addition, I acknowledge all household information provided is true and accurate. The Parks & Recreation Department may request further verification regarding the information provided.

Adult Signature: ____ Date ________________________________

PAYMENT INFORMATION

Payment Type: [ ] Check #_______ [ ] Cash _______ [ ] Credit Card **Program Fees Subtotal** $ _________

Donation for camp fund (Provides assistance for families unable to afford program fees for summer camp.) **Donation** + _________ (optional)

Credit Card Signature _______________________________ Date __________ **Total Amount** $ _________

I agree to pay the total amount according to the cardholder agreement. Please refer to refund policy in brochure.

[ ] Visa [ ] Mastercard [ ] Discover _________ - ________ - _______ - _______ Exp. Date ____ /_____

Keane on Kids After School Enrichment Program Supplemental Registration Form

Please be specific when providing the following information and submit with your registration form

Participant's Name ______________________________

Participant's School Teacher's Name ______________________________

Does the Participant Have Special Medical Needs? ______________________________

Does Your child Have Any Allergies: ______________________________

Does Your Child Have an EpiPen? Yes No

If Someone Other Than Parent/Guardian is Picking Up, Please Indicate Here:

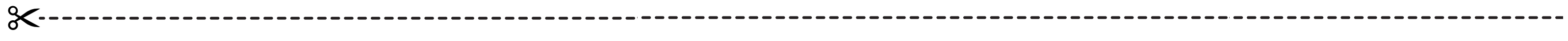
Name ______________________________

Phone Number (during after school hours) ______________________________

Will Your Student be Walking Home? (Circle one) Yes No

______________________________ ______________________________

Participant Signature (or Parent/Guardian) Date



Therapeutic Recreation Program Supplemental Registration Form

Please be specific when providing the following information and submit with your registration form

Participant's Name ______________________________

Primary Disability ______________________________

Any Assistive or Adaptive Device(s) used ______________________________

Any Medications ______________________________

Side Effects Staff should be Aware of ______________________________

Allergies ______________________________

Special Considerations Not Mentioned Above (especially related to medical or behavioral needs)

____

Special Interests ______________________________

Goals You Wish to See from this Program ______________________________

I give my permission for transportation to be provided in an authorized town vehicle to TR activities. Yes ___No ___

______________________________ ______________________________

Participant Signature (or Parent/Guardian) Date