

REGISTRATION FORM

NAME(S) _____
ADDRESS _____
PHONE _____
EMERGENCY # _____
E-Mail Address _____
AGE(S) _____
PROGRAM(S) REGISTERING FOR _____

MEDICAL INFO _____

I hereby give permission for a picture to be taken and used in publicity for dept (no name) Yes No

I hereby give permission to the person(s) named above to participate in the named program(s). I will hold harmless the Town of Cromwell, its officials, officers, agents and employees for any financial liability or obligations which the named person personally incurs or injury or damage to the person or property of others which the named person causes or contributes to while participating. I understand that the named person is responsible for exercising caution and common sense at all times to avoid injury. I will carry health and life insurance to cover injury or illness during the program(s). I acknowledge that I have read all program related descriptions and materials and agree that the named person(s) shall abide by all rules and regulations.

SIGNATURE OF PARENT/ADULT _____
PRINTED NAME PARENT/ADULT _____
OFFICE USE: _____