

# FALL REGISTRATION FORM

In case your first choice is filled, list a second time choice. If both choices are filled, you will be placed on a waiting list for your first choice and sent a confirmation card in the mail. If this form is incomplete or incorrect your registration will be delayed or returned. **Drop-off or mail this form to the Palatine Park District, c/o Registration, 250 E. Wood Street, Palatine, IL 60067-5358 or drop-off this form to the Birchwood Recreation Center, 435 W. Illinois, or fax this form to 847-202-7317.**

**PLEASE PRINT**

FOR OFFICE USE ONLY							
CA	CK	CG	R	NR	SR	SCH	EMP
checked by _____				date _____			
processed by _____				date _____			
batch # _____							

Date \_\_\_\_\_ Payment being made by \_\_\_\_\_  
(last name) (first name)

Participant Home Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ New Address? (since last registration)

Prog #	Program Name	Registrants' Full Name	Sex	Birthdate	T-Shirt Size <small>(if applicable)</small>	Fee
	1st Choice					
	2nd Choice					
	1st Choice					
	2nd Choice					
	1st Choice					
	2nd Choice					
	1st Choice					
	2nd Choice					
	1st Choice					
	2nd Choice					
	1st Choice					
	2nd Choice					

FALL FORM

I would like to charge my registration to  VISA  MASTERCARD  DISCOVER

Cardholder's name (print) \_\_\_\_\_

Expiration date \_\_\_\_\_ Card number \_\_\_\_\_

Amount of charge \_\_\_\_\_ Authorized Signature \_\_\_\_\_

All REFUNDS will be charged a \$5 processing fee. Our refund policy is 100% up to 10 days before class starts and 50% up to 24 hours after 2nd class. Some classes are non-refundable. Medical refunds are subject to review. Please refer to the catalog for more information. **NO NET REFUNDS UNDER \$5 WILL BE ISSUED.** Refunds are not given if there is a change of instructor, for one day programs, special events, or classes which are contracted or require ticket purchases. Refunds for anything paid by VISA, MASTERCARD, or DISCOVER will be processed directly through your charge account.

**Total \$**

**ALL PARTICIPANTS LISTED ABOVE MUST SIGN THIS SECTION**

By their very nature, many Park District programs involve body contact, substantial physical exertion, emotional stress, and/or use of equipment which represents a certain risk. It is recommended that you check with your physician prior to participating in Palatine Park District activities. Palatine Park District does not provide insurance protection for participants in Park District activities. Please read the following information carefully and be aware that in registering yourself or your minor child/ward for participation in the above program(s), you will be waiving and releasing all claims for injuries you or your child/ward might sustain arising out of the above program(s). I give my child permission to participate in this program, trip, or activity and hereby waive, release and forever discharge any and all claims against the Palatine Park District or its commissioners, employees, or volunteers for damages and/or injuries to the registrant, which may arise from participation in Palatine Park District programs. **EMERGENCY TREATMENT:** A minor may not be treated, even in an emergency, except when, in the opinion of the attending physician, a life is in the balance. Written consent is required for all treatment given in any hospital emergency room/center. Consent of a parent or legal guardian is necessary for unmarried minors, under 18, except in cases of extreme emergencies. **TO WHOM IT MAY CONCERN:** As a parent and/or legal guardian, I do herewith authorize the treatment by a qualified and licensed medical doctor of the above minor in the event of a medical emergency which, in the opinion of the attending physician may endanger his/her life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me. The release form is completed and signed of my own free will with the purpose of authorizing medical treatment under emergency circumstances in my absence. Please list specific medical allergies, medicines, or other conditions on a separate piece of paper to be attached to this form.

Parent/All Adult Participants (must sign) \_\_\_\_\_

Emergency name (other than listed above) \_\_\_\_\_ Emergency phone (other than listed above) \_\_\_\_\_

Please indicate any medical information (asthma, diabetes, etc.) or food allergies that staff should be aware of \_\_\_\_\_