Summer Registration Form

(Please Print)

Parent/Guardian:______________________________ _____________________________________

Address: _____________________________ City: ______________________ Zip:____________

Primary Phone #: (______)___________________ Day Time #: (______)________________

Email: ____

(please print)
Participant Name:______________________________________ M / F Birth Date:____/____/______ Age:___

Grade Entering	Shirt Size (if applicable)	Activity Name	Activity #	Fee

(please print)
Participant Name:______________________________________ M / F Birth Date:____/____/______ Age:___

Grade Entering	Shirt Size (if applicable)	Activity Name	Activity #	Fee

(please print)
Participant Name:______________________________________ M / F Birth Date:____/____/______ Age:___

Grade Entering	Shirt Size (if applicable)	Activity Name	Activity #	Fee

Shirt Sizes Available: Youth Small (6-8) Medium (10-12) Large (14-16) Adult Small Medium Large

Note: Enrollment for Summer Blast, Camp Marshalltown or MTA requires a different registration form available at the Parks and Recreation office or can be downloaded from our website (www.marshalltownparkandrec.com)

Parental Permission

1. I/We recognize and agree that as participants or observers I/we shall bear the full responsibility of any loss or theft of personal items while engaging, participating, or observing in these activities.
2. I/we release any photographs, videos, or both taken during the activity to be used by the City of Marshalltown for advertisements, training, or other purposes.
3. In the event of injury or illness, I hereby give my consent for medical treatment, and permission to program staff for supervising and performing, as deemed necessary by staff, on-site first aid for minor injuries, and for a licensed physician to hospitalize and secure property treatment (including injections, anesthesia, surgery, or other reasonable and necessary medical or surgical procedures) for me or my participant or observing spouse, if I am unable to provide that consent directly at the time, for any reason. I agree to assume all costs related to any such medical or surgical treatment., I also authorize the disclosure of medical information to my insurance company for the purpose of this claim.

Parent/Guardian Signature: ______________________________ **Print Name:** ___________________________

Must provide an email address for a receipt of payment when registration is received via mail.

For Credit Card Payment ONLY

Name on Card:____ Card Type (please circle): MC VISA AMEX

Card #:____ Exp. Date (MM/YY): ______/______ CVC# ________