

**REGISTRATION FORM with HEALTH & EMERGENCY INFORMATION**  
**WESTMOOR PARK, 119 Flagg Road, West Hartford, CT 06117**  
**Phone: 860-561-8260; Fax: 860-236-3815; email:westmoorpark@westhartford.org**  
*Please complete separate form for each participant*

**PARTICIPANT'S NAME** \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Entering Grade \_\_\_\_\_ (if applicable)

\*Has participant been prescribed an Epi-pen? No \_\_\_\_\_ \*Yes \_\_\_\_\_ \* (if yes, an Epi-pen form will be sent to you)

**SPECIAL CONCERNS: List any special needs or health or behavioral issues of participant:** \_\_\_\_\_

PROGRAM #	TITLE	DATES	TIME	FEE
<b>PAYMENT TYPE:</b> Cash _____ (in person only)      Check # _____ (payable to "Town of West Hartford")			<b>TOTAL</b>	

VISA     Master Card   

Expiration Date:   /

*Month      Year*

**PLEASE COMPLETE IN FULL:**

**Parent/Guardian (Please Print)**  
 FULL Name \_\_\_\_\_  
 Street \_\_\_\_\_  
 Town \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_ Home # \_\_\_\_\_  
 Cell # \_\_\_\_\_ Work # \_\_\_\_\_  
 Household E-mail \_\_\_\_\_

**Parent/Guardian (Please Print)**  
 FULL Name \_\_\_\_\_  
 Street \_\_\_\_\_  
 Town \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_ Home # \_\_\_\_\_  
 Cell # \_\_\_\_\_ Work # \_\_\_\_\_  
 Household E-mail \_\_\_\_\_

**Additional Emergency Contacts** \_\_\_\_\_ Relationship \_\_\_\_\_  
 Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

I realize that as with any physical activity there is a possible risk of accidental injury to me/my child while participating in this West Hartford Leisure Services Program. I agree to assume the risk of any injury which I/my child might suffer while involved in the West Hartford Leisure Services Program and will not hold the Town of West Hartford or its instructors liable for any injuries which I/my child may suffer while participating in this West Hartford Leisure Services Program.

**Signature of Parent or Guardian:** \_\_\_\_\_ **Date** \_\_\_\_\_

**HEALTH AND EMERGENCY INFORMATION**

**This part MUST BE COMPLETED when registering a CHILD for CAMP programs (running 3 HOURS OR MORE A DAY).**

Please list and describe any known allergies, illnesses, physical limitations, special needs, health or behavioral concerns etc. \_\_\_\_\_

**List Medications** \_\_\_\_\_

**Family Doctor's Name** \_\_\_\_\_ **Doctor's Phone Number** \_\_\_\_\_

Please read below and if you understand and agree to each statement write your initials in the space next to the paragraph to signify your understanding and agreement.

\_\_\_\_\_ In the event my child needs emergency hospital or medical care while participating in this West Hartford Leisure Services Program and there is no time for me to be contacted and/or I cannot be reached, my hospital preference is: **Hospital Name** \_\_\_\_\_

\_\_\_\_\_ However, if circumstances are such that it is deemed necessary to admit elsewhere, permission is hereby granted.

\_\_\_\_\_ In the event my child needs emergency medical care while in this West Hartford Leisure Services Program, I hereby give permission for the hospital to give such emergency treatment as is considered necessary or desirable by medical judgment, including administration of anesthesia.

\_\_\_\_\_ In the event that my child needs to be transported by an ambulance, I give my permission for such transportation and I agree to assume all expenses incurred by said transportation.

\_\_\_\_\_ I agree to assume all medical expenses incurred by my child while participating in this West Hartford Leisure Services Program.

\_\_\_\_\_ **FIELD TRIPS:** I hereby give my permission for my child to go on the field trips scheduled for his/her particular camp program. The exact schedule will be provided to me at the beginning of the camp session. If I do not wish my child to attend the field trip, I understand that I will make other arrangements for my child on that day.