

# HARBOR CITY RECREATION CENTER

## CLASS / ACTIVITY REGISTRATION FORM

<b>ACTIVITY:</b> _____	
<b>SESSION:</b> <input type="checkbox"/> WINTER <input type="checkbox"/> SPRING <input type="checkbox"/> SUMMER <input type="checkbox"/> FALL <b>YEAR:</b> _____	
<b>P A R T I C I P A N T</b>	Last Name _____ First Name _____  Birthdate ____/____/____      Age _____ <input type="checkbox"/> Male <input type="checkbox"/> Female  Street Address _____  City _____      Zip Code _____  Mobile Phone (_____) _____      Home Phone (_____) _____  E-mail _____  Emergency Contact Name _____      Home Phone (_____) _____  Work Phone (_____) _____      Cell Phone (_____) _____
<b>M I N O R S</b>	Parent /Guardian _____      Home Phone _____  Work Phone _____      Cell Phone _____      E-mail _____
<b>PLEASE CHECK BELOW IF YOU ARE INTERESTED IN VOLUNTEERING IN THE FOLLOWING:</b> <input type="checkbox"/> COACHING <input type="checkbox"/> TEAM MOM / DAD <input type="checkbox"/> PARK ADVISORY BOARD <input type="checkbox"/> SPECIAL EVENTS	
<input type="checkbox"/> <b>Consent Form for Minor</b>	I, the undersigned, give permission for my child, whose name appears above, to participate in the <b>Harbor City Recreation Center</b> program. I understand the nature of the activities and the minor's experience and capabilities and believe the minor to be qualified, in good health, and in proper physical condition to participate in such activity. I agree to relieve the City of Los Angeles Department of Recreation and Parks, its officers, agents and employees from any liability in connection with any injury to my child in connection with this activity. I understand the Recreation Facility CARRIES NO INSURANCE. I, the undersigned parent of _____, a minor, do hereby authorize <b>Harbor City Recreation Center</b> as agents for the undersigned to consent to X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or specialized supervision of any physician licensed under the provisions of the Medical Practice Act on the staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or a said hospital. It is understood that this authorization is given in advance of any such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable. This authorization shall remain effective for the duration of the program, unless revoked sooner in writing and delivered to said agent.  Signature of Parent / Guardian _____      Date _____
<input type="checkbox"/> <b>Consent Form for Adult</b>	I, the undersigned, am aware that <b>Harbor City Recreation Center</b> and/or The City of Los Angeles Department of Recreation and Parks CARRIES NO INSURANCE. I understand the nature of the activities and my experience and capabilities and believe I am qualified, in good health, and in proper physical condition to participate in such activity. I agree to relieve the City of Los Angeles Department of Recreation and Parks, its officers, agents and employees from any liability in connection with any injury to me in connection with this activity. I, _____, do hereby authorize <b>Harbor City Recreation Center</b> as agents for the undersigned to consent to X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or specialized supervision of any physician licensed under the provisions of the Medical Practice Act on the staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or a said hospital. It is understood that this authorization is given in advance of any such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable. This authorization shall remain effective for the duration of the program, unless revoked sooner in writing and delivered to said agent.  Signature of Adult Participant _____      Date _____

**RECIPT #** \_\_\_\_\_

**AMOUNT:** \_\_\_\_\_

**STAFF INITIAL:** \_\_\_\_\_