



**PARKS, RECREATION & COMMUNITY SERVICES DEPARTMENT  
TEEN CENTER DROP IN PROGRAM 2011-12 Membership Application**

STUDENT INFORMATION

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Male       Female      DOB: \_\_\_\_\_

Age: \_\_\_\_\_ Grade: \_\_\_\_\_

MEDICAL/GENERAL INFORMATION

Does your child have any of the following?

- ADHD
- Asthma
- Convulsions
- Diabetes
- Heart Trouble
- Needs Medicine (if YES, please complete medicine form)
- Any Disabilities or Special Needs If yes please list below.
- Any abnormal fears? (Use space below to list or explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

CONTACT PARENT 1

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ ZIP: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Wk Phone: \_\_\_\_\_

Alternate Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

CONTACT PARENT 2

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ ZIP: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Wk Phone: \_\_\_\_\_

Alternate Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

**AUTHORIZED PICK UP (Persons listed below are authorized to pick up my child):**

1. Name: \_\_\_\_\_

Phone: \_\_\_\_\_

2. Name: \_\_\_\_\_

Phone: \_\_\_\_\_

3. Name: \_\_\_\_\_

Phone: \_\_\_\_\_

REGISTRATION AND FEES PAYMENT

**Note :** Fees are due by the following dates otherwise your child may not participate . \$50.00 FALL Semester September 16, 2011. \$50.00 Spring Semester January 20, 2012. You may pay in one lump sum if you like. There are no refunds after the registration deadline has passed

# WAIVER AND CONSENT TO TREAT

STUDENT: \_\_\_\_\_

ACTIVITY: Teen Center

**PLEASE NOTE: The Teen Center will continue to be a drop in program. We are open on early dismissals days and are closed on non-school days.**

## RELEASE

I hereby give permission for the minor in my custody to participate in the above-mentioned activity and hereby waive, release and discharge any and all claims or rights to claims for damages for death, personal injury or property damage which I may have or which may hereafter accrue to me, as a result of said minor's participation in said activity. This Release is intended to discharge in advance the promoters, sponsors, the City of Culver City, the officials and any involved municipalities or other public entities (and their respective agents and employees), from and against any and all liability arising out of or connected in anyway with said minor's participation in said activity, even though that liability may arise out of negligence or carelessness on the part of the persons or entities mentioned above.

I further understand that serious accidents occasionally occur during said activity, and that participants in such activity occasionally sustain mortal or serious personal injuries, and/or property damage, as a consequence thereof. Knowing the risks of said activity, nevertheless, on behalf of said minor child, I hereby agree to assume those risks and to release and hold harmless all of the persons or entities mentioned above who, through negligence or carelessness, might otherwise be liable to me, or my heirs or assigns for damages.

It is further understood and agreed that this waiver, release and assumption of risk is to be binding on my heirs and assigns. I agree to accept and abide by the rules and regulations of the City of Culver City. I give my permission to the City of Culver City to photograph me or my children participating in the programs for use in City of Culver City publicity and publications and I will not seek compensation for such use.

\_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN

\_\_\_\_\_  
DATE

## CONSENT TO MEDICAL TREATMENT OF MINOR

"In the event of sudden illness, accident or injury which may occur while said minor is engaged in an activity supervised by the City of Culver City – Parks, Recreation & Community Services Department and their representatives, agents or assignees, when neither parents, guardian or designated family physician can be contacted, I hereby give my consent pursuant to California Civil Code, s25.8, for emergency treatment as shall be necessary under the circumstances by any physician licensed under the Laws of the State of California."

\_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN

\_\_\_\_\_  
DATE

Family Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Medical Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

### **Emergency Contact:**

1. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

2. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

3. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

### *FOR OFFICE USE ONLY*

Date Received: \_\_\_\_/\_\_\_\_/\_\_\_\_

Registration Taken By: \_\_\_\_\_

Amount Paid: **Full \$100.00**      **Fall Only \$50**      **Spring Only \$50**